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Semiotic Considerations on Borderline Personality Disorder

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I have written the Master Thesis myself, independently. All of the other authors' texts, main viewpoints and all data from other resources have been referred to.

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Introduction

The major aim of the following work is to analyze the relationship between the mental disorder diagnosis and a person labeled by it. Since the science of semiotics is largely concerned with the study of meaning making processes, the topic manifests itself relevant for the semiotic research as it gives the possibility to approach the mental disorder label as a meaning creator mechanism capable to affect several aspects of a person's cognitive and behavioral functioning.

There is no shortage of disagreement when it comes to discussion around mental health related problems. If we were asked to make a list of the most problematic topics and controversial theories, discourse over mental health would be in the top of such a list. Unlike physical illnesses, mental diseases have always been ambiguous by their nature, posing a great deal of questions, including the question of their own validity.

In present day, views on the mental illnesses range from understanding them in a same manner as physical illnesses to approaching mental diseases as socially constructed phenomena. Adherents of the former practice follow the steps of modern psychiatry and welcome different kinds of treatment offered for those affected by mental conditions, while others accuse psychiatrists in over-diagnosing individuals. More radical criticism suggests that mental disorder as invented, not identified. The question then arises, does constructed mean unreal? This subsequently leads to a number of heated discussions, in most cases without achieving the consensus.

Clearly, whether 'real' or 'constructed', mental disorders regardless different understandings and associations they evoke, do exist and are manifested in the lives of individuals either afflicted by them, treating them or witnessing them. Along with the development of psychiatric practices, number of the identified mental disorders together with people diagnosed increases. Evidently, what is common for all kinds of illnesses is the presence of a label. All disorders require their names in order to be valid, identified and further defined. Analyzing the functioning of such a label in regard of a person's relationship with it is a very major concern of the following work. Not to choose a

premature approach with an attempt to overgeneralize the topic and squeeze different kinds of mental illnesses into one research, the thesis focuses on the specific mental disorder and dwells on the effects of being labeled by it.

The Study Object

Among the kinds of mental disorders, we encounter the notion of the personality disorders that are defined as the fixed patterns of an individual's perceptions and behaviors, deviating from norm. Unlike other mental conditions, personality disorders are qualified as long-standing and pervasive. The study object of the following paper, borderline personality disorder (BPD), is clinically known as a severe form of psychopathology, mainly characterized by the instability and extreme intensity of emotions, uncertainty of self-concept (identity disturbance) and impulsive, self-destructive behavior. The term 'borderline' was first used in the late 1930s, but the condition as it is known today, gained its identification as a mental illness only in 1980.

Borderline personality disorder, due to its distinguishably complicated quality undoubtedly produces terrains of vagueness and eminently attracts the researchers interested in the field. As described by the clinicians, BPD stands out from the rest of the personality disorders as the most researched and paradoxically enough, still the least understood, confusing even the experienced mental health professionals.

In many ways, the borderline syndrome has been to psychiatry what the virus is to general medicine: an inexact term for a vague but pernicious illness that is frustrating to treat, difficult to define, and impossible for the doctor to explain adequately to his patient" (Kreisman, Straus 2010: 7)

This can be partly explained by the high level of heterogeneity of the disorder, as BPD symptomology combines quite vast set of symptoms. Furthermore, according to present psychiatric knowledge, BPD shows a very high rate of comorbidity as in majority of cases, people diagnosed with BPD also have some co-occurring disorder. "Additionally, studies corroborate that about 90 percent of patients with the BPD diagnosis also share at

least one other major psychiatric diagnosis” (Kreisman, Straus 2010: 6).

In fact, BPD positions itself as a highly challenging mental illness for both its sufferers and mental health professionals. Naturally, the more complicated a context of a condition covered by the single label is, more intricate accessing oneself becomes for the person, looking through the lenses of the label. A very strong stigma attached to the condition deeming those diagnosed with it as manipulative, attention-seeking, draining and even dangerous, definitely adds up on the perceptions that can be derived from the label alone.

Borderline Personality Disorder (BPD) and “difficult patient” status are intimately linked. One study found that “psychiatrists mentioned the diagnosis of Borderline Personality Disorder up to four times more often than any other diagnosis when asked about the characteristics of difficult patients” (Koekkoek et al., 2006:797). Several more have indicated that almost all difficult patients have “borderline personality organization” (See Koekkoek et al., 2006, Group for advancement of psychiatry 1987; Fiore, 1988; Schwartz and Goldfinger, 1981). The very symptoms and behaviors associated with BPD are linked with how providers define the “difficult patient.” Kelly & May (1982) found that behaviors such as mutilation, chronic illness, rule-breaking behavior, aggressive, uncooperative or won't accept care, or need too much care, and are destructive, willful, attention-seeking and manipulative have been linked with negative attitudes toward patients. (Sulez 2015: 82)

The following work aims to explore the relationship of a person and the label obtained in the example of borderline personality disorder, taking into account all the challenge the diagnosis poses.

Methodological Considerations

For the sake of providing comprehensive analysis, significant attention is paid to the problematic discourse on the mental health problem. The question of understanding the word ‘constructed’ without invalidating an essence of one’s psychological condition is addressed. The discourse leads us to the terrain of finding the middle ground between radically opposed positions, putting some groundwork for the further and more specific examination of the research, which is the functioning of the label.

The theoretical part of the thesis consists of the historical-descriptive and discourse analysis, concerning the validity of mental illness, called into question by some of the

critics. The analysis of the diagnostic features of the condition is based on the fifth and most recent edition of *Diagnostic and Statistical Manuals of Mental Disorders* (DSM), published by *American Psychiatric Association* (APA). There is another system offered by *World Health Organization* (WHO), which allocates mental disorders in *International Classification of Diseases* (ICD). The reason for choosing DSM over ICD is that most of the assessment methods, tests and researches on BPD or any other mental disorder are based on DSM. In fact, ICD-10 does not clearly define BPD as a fixed diagnosis, but refers to it as Emotionally Unstable Personality Disorder that is divided into two types: Borderline type and Impulsive type. However, overall description of the condition mainly matches with DSM criteria for BPD diagnosis.

The empirical part of the paper analyses the biographical interviews conducted with individuals having BPD, results of which are approached in terms of Lotmanian semiotics. The role of one's self-description in the process of internalizing the mental disorder label is stressed, as well as the reasons of difficulties in the communication and the functioning of BPD label as a code in the autocommunicative process is discussed. Bearing the first person relationship to the diagnostic label, thus being directly connected to the study object, interviewed individuals are in the best position to offer the valuable insights regarding the various aspects of BPD manifestation.

The participants of interviews have been selected from the online support group for people with borderline personality disorder. They have been informed about the purpose of the interviews, as well as the aspect that their names and some of the data could be revealed in the thesis. Interviews have been conducted in online regime, using personal electronic mail. The written online form has been chosen over the oral phone conversations, as in the former case a person has more time and space to process the question and reflect on it accordingly. The open-ended questions have been sent to the respondents one at a time, so that the process could be interactive, enabling the person to engage into the communication with an addressee being present, rather than answering all the questions received at once, which might have felt as filling a questionnaire.

The research participants are coming from different cultures, seven of them is from the

United States of America, one is from Puerto Rico (the citizens of which are technically citizens of USA too), two from the United Kingdom and one from Estonia. Here the cultural specificity aspect must be mentioned. While generally speaking, the illness can affect anyone regardless of race and nationality, it can be said that borderline personality disorder is a culture-specific in a sense of being informatively available. Given that the ‘discovery’ of it took place in English speaking society, that the original name of it is in English, the whole majority of the literature providing the knowledge and information on the topic is available in English only and the diagnostic manuals of it are also originally written in English (like of any other mental disorder), gives the base to say that knowledge of the condition is specific to the English speaking societies.

Again, it does not mean that people from the Eastern cultures are protected from the occurrence of BPD symptoms. What it implies is that there may exist manifestations of the condition, but if it is not accompanied with the awareness and ability of recognizing it, it cannot be identified and defined, that is, cannot be labeled. In this sense, it can be said that there exists no such diagnostic condition as borderline personality disorder in the consciousness of the general public of eastern societies, while it may still exist there on its own, manifesting itself among the certain individuals. However, if these certain individuals do not become worried enough about their unusual state of being, leading to approach a mental health professional and getting the diagnosis, they may never come across with the notion. And even if they do get the diagnosis, they would need to get acquainted with their diagnosis, which again leads to the domination of English language, implying that they would not be able to fully comprehend the topic unless they speak English.

Another specificity revealed is the gender aspect. As it is discussed in the second chapter BPD is considered to be an illness of women, as it is mostly diagnosed in women (The validity of this point is discussed in 1.3.2.). In correspondence of the general statistics, nine out of eleven interviewees are female. The age of the youngest participant is twenty-two and the oldest is forty-three years old. The responses on the opening questions showed that the whole majority of respondents are socially functioning, either working, or studying. Also, most of them are married or have a romantic partner. One of the

respondents currently lives in a mental health unit.

Finally, the language used by the interviewees, including slang and slightly obscene terminology is remained intact as it gives the ability to fully comprehend the original ideas of a person interviewed.

Structure of the Thesis

As mentioned earlier, the following work consists of the theoretical and empirical pieces. The thesis is divided into three main chapters. The first chapter presents the discourse on the dilemma of mental illness validity. A historical overview of the changeable meanings attained to the conditions nowadays categorized as mental disorders, contributes to the better understanding of the conventionality of social implications. Coming next, the theoretical analysis of dispute regarding the mental health related problems devotes attention to such problematic issues as searching for the middle path between approaching mental illness as made-up or strictly factual, analyzing the impreciseness of the line between normal and pathological, approaching illness as a purely subjective notion and determining the mutual interaction between people and their classifications.

The second chapter of the thesis gives the descriptive account on its study object, which is borderline personality disorder. Here the detailed overview of the existing knowledge on the condition is presented. The brief historical survey in terms of emerging and developing the diagnosis is followed by examination of the present diagnostic criteria for BPD and main features of the disorder. Finally, the discourse on the etiology of the illness is presented and the problem of the stigma attached to the diagnosis is brought to attention. The chapter serves as an important element of providing the interdisciplinary account, allowing the readers with different academic backgrounds to become acquainted with the subject under the discussion.

The last analytical chapter of the thesis sets forth the concepts of cultural semiotics. The notions of self-description, communication modeling systems and autommunication are

introduced and discussed in the first part of the analysis. The final part of it analyses the interviews conducted with eleven individuals diagnosed with borderline personality disorder and conceptualizes the results in cultural semiotic framework discussed in the preceding subchapters.

The conclusion briefly goes through the major points of discourse provided in the work. It sums up the outcomes and achievements of the research performed. While demonstrating what the study has shown, it also addresses the issues that may need further contribution. A relevance of the topic to the field of semiotics and the advantages of semiotic approach to the topic is once again accentuated.

The major concern of this work is to provide a thorough theoretical analysis on the obscure essence of mental illness and the meaning-generating role of its labels. A practical intention of the paper is to examine the supplementary processes of getting labeled with a mental disorder diagnosis, interpreting the results in the light of cultural semiotics.

Overall, the following work aims to approach the dilemma of realness and constructiveness of the mental illnesses from the different angle and intends to further investigate the actual semiotic relationship, taking place between a person and their diagnosis.

1. Mental Illness: Constructed or Real?

The following chapter aims to provide a discourse on the dispute related to the topic of mental health, gaining a growing attention in recent years. The question whether mental illness should be approached in the same manner as physical illness has been a base of continual heated debates. With the growth of information on different mental disorders, the skepticism prevailing in one part of the society intensifies. Radically inclined critics argue that mental disorders are not real illnesses as such, but social constructs. Naturally, such a perspective causes resentment and gets condemned by the people fighting the stigma of mental health related problems, considering such an attitude as a form of discrimination, causing an additional trauma for the people with the psychological vulnerabilities.

Certainly, someone identifying as a survivor of the severe psychological challenges is highly likely to find oneself invalidated being told their struggle is not real. The commonly-held attitude of general public, not taking the mental health issues of people seriously, is exemplified by offering them such advices as ‘get over it’, instead of providing support as it appears natural in case of experiencing a physical illness. In this sense, such a stance can be understood as another shape of stigma, ‘the strategy’ of which is to abolish the entire concept of a problem, making someone with mental illness look fraud attention-seeker, or a weak person in a better case. Unsurprisingly, it may further encourage people’s secretiveness about their mental health problems, hindering them from seeking help they need.

Whilst on one side we encounter the tendency of invalidating the feelings of certain population of the society, on the other hand we face growing number of people obtaining stigmatizing labels of different mental disorders, which one may take as a sign of the practice of over-diagnosing. In its attempt to find the middle ground between two conflicting positions, this paper claims that the question of whether mental illness is real

or constructed is inaccurate in its essence. In other words, it argues that the aforementioned problem cannot be solved with the mathematical accuracy whereas something equals something and only something. Rather, saying that mental illnesses are to some degree socially constructed does not exclude that in their functioning they are real and saying that they are real does not exclude their constructedness. Instead of putting forward an unequivocal claim, mental illnesses can be deemed constructed in their realness and real in their constructiveness. To put this viewpoint differently, it can be formulated as follows. Mental illnesses in a sense of being classified, categorized and labeled are socially constructed. Yet, it does not imply that mental struggles certain individuals experience are made up. Moreover, it can be argued that mental and physical illnesses are much more interconnected than we may assume, considering the subjective value of the illness itself.

The opening section of the following work serves as a tour guide to the earlier centuries, exploring how the meaning of mental illness has emerged and evolved through the history of mankind. In other words, it features the path of different interpretations phenomenon went through on its course of converting from ‘madness’ into ‘mental illness’ as understood in a present day. The main purpose of the section is to draw attention to unsteadiness of socially established meanings attached to such conditions.

In the following part the discussion revolves around the dispute on the validity of mental illness, presenting the major opposing viewpoints regarding its realness. The analysis provided here is a modest contribution to the discussion presented, with the goal to introduce the middle-path solution, approaching the problem from the different angle. Next subchapter focuses on the differentiation between the ‘normal’ and ‘pathological’ that is a serious dilemma of humankind and becomes the central issue for physicians diagnosing individuals with psychopathologies. The account is given on the perspectives of comprehending abnormal behavior and mental illness, stressing the importance of distinguishing one from another. The thorough analysis of the topic is provided, supplemented by the supporting materials. The final part of the chapter concentrates on the interaction between the classifications and people labeled and thus classified. Attention here is paid to the meaning-generative nature of a mental disorder label,

covering the set of symptoms and carrying a specific significance within it.

1.1. To the Roots of Mental Illness - from Antiquity to Today

1.1.1. Madness in the Ancient World

Different forms of mental illness have manifested itself very long before being captured by the psychiatric knowledge. In fact, insanity has been an inspirational theme for the world's various artists and writers, leaving its trace on the different forms of art. From the ancient times to the present day, human being have been in touch with the various states of mind, deemed disordered. Seemingly, perceptions linked to these disordered states had the tendency to change dramatically from one epoch to another. British Historian, Roy Porter has considered (2002:10) madness to be as old as mankind, pointing out that archaeologists have found skulls with small holes, datable back to at least 5000 BC, that have been acknowledged as the evidence of the trepanning practice to be present in the prehistoric era. Trepanning was thought to free the disturbed person, as drilling the skulls would allow the demonic spirits to leave the body of a human.

Precisely, in antiquity manifestation of madness was largely linked with supernatural powers. People behaving in a different and unusual ways qualified as such by their contemporaries, were destined to be stated as ones possessed by the devils. "The Babylonians and Mesopotamians held that certain disorders were caused by spirit invasion, sorcery, demonic malice, the evil eye, or the breaking of taboos; possession was both judgment and punishment" (Porter 2002: 12).

Furthermore, the occurrence of madness as a fate of punishment can be found in the passages of the Hebrew Bible. According to the Old Testament, the first king of the Israelites, Saul, and Nebuchadnezzar, the king of Neo-Babylonian Empire disobeyed god in their actions, as a result of which both 'went mad'. As it follows in the biblical story, Saul started out very well, but got into disappointing god in the end. Lastly, not obeying god's direct command to destroy all the people of Amalekites and their livestock (Samuel

15:3) the lord estranged Saul and he got haunted by the evil spirit, driving him mad. A historian of psychiatry, Andrew Scull pays attention to this biblical example in his thorough account on the history of madness.

That the Jews believed Saul's madness was a curse from God is made clear in the verses of the book of Samuel. The precise nature of his madness is less clear, though we know something about its external manifestations. Some sources speak of him being 'choked', and Samuel's account describes rapid shifts in mood, from a depressed and withdrawn state to rampant pathological suspiciousness, raving and episodic violence, including a murderous assault on his own son, Jonathan. (Scull 2015: 17-18)

According to the bible, neither did the great king Nebuchadnezzar escape his punishment from god. Being immersed in his wealth and power he began forgetting that everything he had was given by god. The king was warned to recognize a supreme power of lord, in face of a horrible dream, depicting him being mad. As he did not listen to this warning, god realized the dream and Nebuchadnezzar was driven insane. After seven years, when his sanity was restored, he humbled himself before god and regained the glory he had. (Daniel 4:3)

However, as Scull clarifies, in the ancient world madness was not always a sign of the devil's possession committed for the purpose of punishment, but sometimes indicated on the opposite events. For instance, prophets who in a logical sense exhibited signs of madness were thought to be divine instead.

Some prophets may well have been seen as mad (and certainly some twentieth-century psychiatrists were tempted to dismiss them as examples of psychopathology). Yet for their contemporaries, believing as they did in a jealous and all-powerful God who spoke routinely through human instruments and who was inclined to visit the most severe penalties on those who defied Him, there must always have been reasons for doubt. Madness they recognized, but prophets who exhibited some of the attributes of insanity might well instead be divinely inspired. (Scull 2015: 19)

Following, according to the sources, the practice of associating derangement of the psyche with either demonic or divine forces was widely accepted by the ancient Greek people as well. Consequently, treating of the mentally ill person was an area of shamans and priests, offering sacrifices and magic incantations as the means of treatment. Scull notes out that Madness, usually linked to the supernatural realm, was a predominant theme in the creations of great Greek dramatists too.

The links between madness and the machinations of the gods are likewise a staple of Greek drama and poetry, so much so that millennia later, Sigmund Freud would call upon Greek myth when he named the psychological trauma he claimed indelibly marked the whole human race the Oedipus complex. Panic, too, is a word that derives from Greek: panikon, of or pertaining to Pan, a god notorious for spreading terror. (Scull 2015: 21)

The dominated mystical views on the mental diseases were challenged by the contemporary Greek physicians, declaring that such illnesses as epilepsy, mania and melancholia had nothing to do with the supernatural forces, rather they, as any other illnesses had the natural origins. An important turn from a supernatural to naturalistic approach was illustrated in the treatise *On the Sacred Disease*, based on the Hippocrates teachings. “With the example of epilepsy in mind, Hippocratic medicine naturalized madness, and so brought it down from the gods” (Porter 2002: 16). Hence, what once was thought to be the result of demonic possession was now proposed to be the product of an unhealthy functioning of a human body. The shamanic spells as the means of cure were replaced with the different forms of a healthy life style, such as exercise and bathing. However, an enlightened view has not quite replaced the supernatural approach, as many in Ancient Greece and Rome continued to believe in the religious explanations of illnesses.

1.1.2. Insanity in the Christian World

According to historians, falling of the Eastern Roman Empire caused the utter literary loss, including the loss of Hippocratic tradition (Scull 2005:50), leading to the total supremacy of religious demonology over the naturalistic views. Hence, in the Christianized Europe the Church became an authorized source for recognizing and treating mentally disturbed people. Now madness was largely considered as the result of one’s sinful life. Exorcism became widely utilized method to cure a mad person as people deviating from ‘norm’, were thought to be plagued by the evil spirits, being in need of driving the demon out of their bodies.

Unclean spirits were to be treated by spiritual means: amongst Catholics, the performance of masses, exorcism, or pilgrimage to a shrine, like that at Gheel in the Netherlands, where Saint Dymphna exercised singular healing powers. The insane were also cared for

in religious houses. Protestants like Napier preferred prayer, Bible-reading, and counsel. (Porter 2002: 19)

As historical sources indicate, medieval European societies were largely immersed in massive poverty, starvation and malady. “And to those largely helpless and dependent victims of misfortune, we may add the mad – epileptic, frenzied, melancholic, hallucinating, demented” (Scull 2015: 70). From the beginning of thirteenth century, demonology leveled up to the witchcraft, explaining the widespread plague and disasters. During the massive and church-authorized hunting on women regarded as witches, burning alive of those accused, was one of the common methods of punishment.

This legal and theological document came to be regarded by Catholics and Protestants alike as a textbook on witchcraft. Those accused of witchcraft should be tortured if they did not confess; those convicted and penitent were to be imprisoned for life; and those convicted and unrepentant were to be handed over to the law for execution. The manual specified that a person’s sudden loss of reason was symptom of demonic possession and that burning was the usual method of driving out the supposed demon. [...] Investigators initially believed that many of the people accused of being witches during the latter Middle Ages were mentally ill (Zilboorg & Henry, 1941). The basis for this belief was the confessions of the accused that investigators interpreted as delusional beliefs or hallucinations. (Kring, Johnson, Davison, Neale 2010: 11)

As Porter states, the witch-hunt hysteria has endured even during the late Renaissance. “In England, as late as the 1630s, a physician as distinguished as Sir Thomas Browne might give evidence in court backing the reality of witchcraft. In other parts of Europe, the demonological debates rumbled on longer” (Porter 2002: 30).

Michel Foucault begins his famous work on the attitudes towards mad in Western society from the end of Middle Ages. Foucault speaks about the fifteenth century’s mindset perceiving madness as the replacement of newly vanished leprosy and regarding a mad man as a sinful creature, who needed to be estranged from the rest of the society. He describes the cases of such ritualized exiling of the mad men out of the community, beating them with sticks and driving them out of the town.

The towns drove them outside their limits; they were allowed to wander in the open countryside, when not entrusted to a group of merchants and pilgrims. The custom was especially frequent in Germany; in Nuremberg, in the first half of the fifteenth century, the presence of 63 madmen had been registered; 31 were driven away; in the fifty years that followed, there are records of 21 more obligatory departures; and these are only the madmen arrested by the municipal authorities. (Foucault 2006: 8)

Foucault further describes the great confinement of the classical age introducing new ways of approaching the mad, when a biological approach took the place of supernatural beliefs, converting a dashed into the beast. That is, a mad person became associated with an insensitive animal that needed to be treated accordingly. Hence, mentally disturbed citizens together with criminals, homeless and poor were sent to correction houses, awaiting a harsh disciplined treatment. Such a practice as holding a person on the chains was accepted as helpful since chains could inhibit a mad man from realizing his animal passions. Foucault speaks (2006: 40) of the General Hospital built in Paris, in 1656, stating that the place was more of the judicial establishment having nothing medical in it. Various sources indicate that contemporary madhouses were equipped with the dreadful dungeons where those disobeying the administrative regulations were sent. As mentioned, by the end of the seventeenth century, the belief that mental illness had the supernatural origins was greatly discounted by the opposite. However, it did not make much change, as demonization was simply replaced with animalization. Moreover, it can be said that confinement era merely dehumanized a mad men and exercised its power over them, using the barbaric methods of ‘treatment’.

Sufferers were generally chained to the walls and to the beds. At Bethlehem, violent madwomen were chained by the ankles to the wall of a long gallery; their only garment was a homespun dress. At another hospital, in Bethnal Green, a woman subject to violent seizures was placed in a pigsty, feet and fists bound; when the crisis had passed she was tied to her bed, covered only by a blanket. when she was allowed to take a few steps, an iron bar was placed between her legs, attached by rings to her ankles and by a short chain to handcuffs. (Foucault 2006: 71-72)

It must be also noted that Porter considers Foucault’s critique of the great confinement to be over-generalized on the example of French jurisdictions of the time, outlining that not the whole Europe has embraced the similar practice. “In Russia, by contrast, state-organized receptacles for the insane hardly appeared at all before 1850, those who were confined being generally kept in monasteries. And across great swathes of rural Europe, few were psychiatrically institutionalized” (Porter 2002: 94).

1.1.3. From Madness to Mental Illness

According to Foucault, in the classical period madness was seen as a consequence of passion, resulting in the irrational movement of unreason and state of non-being, exemplified in the moments of delirium and hallucinations experienced by the insane mind. Two main disordered states became widely recognizable in the sixteenth-seventeenth century's Europe – Mania and Melancholia. The *Anatomy of Melancholy*, published in 1621, described symptoms of melancholia such as sadness, despair and fear as occurring without any particular reason. Mania, on the other hand was marked with uncontrollability of excitement. It was in the end of seventeenth century, when the two became acknowledged as interrelated diseases, what today can be associated with the diagnosis known as a bipolar disorder.

It is Willis, with his spirit of observation, the purity of his medical perception, whom we honor as the "discoverer" of the mania- melancholia alternation. [...] What he first discovered was an internal relation which engendered strange metamorphoses: "After melancholia, we must consider mania, with which it has so many affinities that these complaints often change into one another". (Foucault 2006: 131)

Another problematic pair of diagnosis was hysteria and hypochondria. The latter denoting having the false belief to be ill and former causing spasms and convulsions particularly associated with women. Foucault explains that physicians attempted to approach hysteria and hypochondria as two sides of the same coin, similarly to the case of mania and melancholia. Despite the inability to discover particular qualities of the conditions, enabling further decipherment of their interrelation, both hysteria and hypochondria remained to be seen as mental diseases at the end of eighteenth century.

The physicians of the classical period certainly tried to discover the qualities peculiar to hysteria and hypochondria. But they never reached the point of perceiving that particular coherence, that qualitative cohesion which gave mania and melancholia their unique contour. All qualities were contradictorily invoked, each annulling the others, leaving untouched the problem of what was the ultimate nature of these two diseases. (Foucault 2006: 139)

Foucault argues (2006: 176) that doctor's relationship with the patient in confinement houses during those times was still very far from the cure-oriented relationship in a medical sense. Rather, it had the moral implications, aiming to purify the patient and

regulate his behavior via punishment. The use of cold-water showers and the dreadful devices was considered as effective therapeutic method, regulating the behavior of the mentally ill in the eighteenth century. Scull further describes (2015: 155-156) one of those machines named the Chinese temple, consisting of a movable iron cage, plunging down into the water with help of pulleys and ropes. A mentally ill person was locked into the device and forced to sink down under the water. The device was believed to distract the patient from his madness, as he needed to concentrate on the surviving from drowning.

The gradual conversion of madness into the mental disease was a decisive movement for the emerging of science of psychiatry. Whereas madness has been seen as a total unreason, mental illness could be approached as the definable states of mind with the specific set of symptoms. The final shift was made at the beginning of the nineteenth century, when confinement practice became largely condemned. Physician Philippe Pinel (1745-1826) is the figure largely associated with the movement demanding the removal of chains from the people with mental illnesses in both literal and metaphorical sense, introducing an alternative approach to treat them. However some authors claim that his reforms were not all-inclusive.

Consistent with the egalitarianism of the new French Republic, Pinel came to believe that patients in his care were first and foremost human beings, and thus, these people should be approached with compassion and understanding and treated with dignity as. [...] Pinel did much good for people with mental illnesses, but he was no paragon of enlightenment and egalitarianism. He reserved the more humanitarian treatment for the upper classes; patients of the lower classes were still subjected to terror and coercion as a means of control, with straitjackets replacing chains. (Kring, Johnson, Davison, Neale 2010: 12)

Along side of flourishing a new approach - moral treatment, madness became isolated from the criminal and ceased being brutalized in the scale of civilized world. Patients with mental illness now were approached as those who should be properly treated on the basis of human psychology and moral concerns, instead of casting out and languishing into the jails. Houses of confinement were replaced with mental asylums. Curing patients and returning them to the society as the fully functioning members was acknowledged as the main goal of mental hospital treatment. Yet, Foucault and his followers have largely criticized (Foucault 2006: 244) this reformatory turn of the psychiatry, suggesting that

new strategy despite of abolishing punitive treatment, still implied moral control over the patients as its main purpose.

Another revolutionary wave took the place in the late nineteenth century, in the face of creating the psychoanalysis. Developing his theories and accentuating an importance of unconscious mental activities, Sigmund Freud laid the base for the upcoming ideas of therapeutic treatments for the twentieth century.

It was already in 1939 when the World Health Organization (WHO) added mental disorders to the *International List of Causes of Death (ICD)* (since 1949, called *International Statistical Classification of Diseases*). Thirteen years later the first version of diagnostic manuals created by American Psychiatric Association (APA) was published. “Even though American psychiatrists had played a prominent role in the WHO effort, the APA published its own *Diagnostic and Statistical Manual (DSM)* in 1952. (Kring, Johnson, Davison, Neale 2010: 64). Nowadays, the DSM is the major psychiatric source, widely used by the clinicians of the world. The most recent, fifth revision of DSM was published in May of 2013.

1.2. Real versus Constructed

1.2.1. Present Dilemma – Myth or Reality?

The growth of information on the mental health brought into light new perspectives of approaching mental illnesses, leading to the structural and categorical differentiation of them. Over the past decades, much attention has been paid to the study of the nature and development of mental disorders. The personality traits ones being demonized, now appeared to find their place in the delicately elaborated diagnostic manuals. The great effort has been devoted to the research of the causes and effective ways of treatment of different mental conditions. There is a rapidly growing literature documenting the features of categorized illnesses and recommending the ways to cope with them. With the

growth of public awareness, psychotherapy has become a part of the life for the significant number of the twenty-first century citizens. Despite these, the topic of mental health still holds highly tense in its ambiguity and vagueness.

To all appearances, psychiatry occupies the unique niche among the branches of medicine. Dealing with the emotional and behavioral problems of patients by means of fitting them into a medical model is what distinguishes psychiatrists from the rest of medical doctors. In this respect, psychiatry has gone under the criticism, questioning the validity of the field in general and accusing its representatives in doing more harm than good. The question whether psychiatry should be identified as an integral part of medicine has been the subject of much debate over the years. Some critics go as far as objecting the whole concept of mental illness and accordingly dismissing the essence of psychiatry. Perhaps Thomas Szasz can be declared as the foremost critic of psychiatry who devoted his career to the fight against the psychiatric practices, requiring redefining of mental health problem. In his best-known work *The Myth of Mental Illness* (first published in 1961) Szasz declared psychiatry as a pseudo-science, engaging in the treatment of something non-existent.

Psychiatry is conventionally defined as a medical specialty concerned with the diagnosis and treatment of mental diseases. I submit that this definition, which is still widely accepted, places psychiatry in the company of alchemy and astrology and commits it to the category of pseudoscience. The reason for this is that there is no such thing as “mental illness. (Szasz 1974: 1)

What Szasz based his core statement on, is a strictly organic concept of illness, recognizing the bodily abnormalities only. It is central to his argument that a mind as the organ of a human body does not exist and accordingly, there is no scientific way to prove the existence of mental illness either. Thereupon, he argued that mental illness is a pure metaphor, applied to the people with problematic lives and has nothing in common with an actual essence of disease. “Strictly speaking, disease or illness can affect only the body; hence, there can be no mental illness” (Szasz 1974: 267). Overall, Szasz accused psychiatry in assuming a role of the moral police, placing a human behavior within the ethical framework, disapproving and stigmatizing it by virtue of inventing ‘so-called mental illnesses’.

Not unexpectedly, his radical outlook has gone under the massive criticism, especially considering his status as a professor of psychiatry. Szasz's ideas got largely dismissed and announced as a failure in his provocative attempt to debunk the essence of psychiatry by his opponents. Nevertheless, he earned an equal praise for the same work by those sharing his ideas. Robert E. Kendell was one of those professors of psychiatry who went into debate with Szasz, responding to his accusations towards psychiatry with a counter-criticism. The main argument of Szasz, based on the body-mind distinction seems unsound to Kendell as he approaches both in the same concept in regards to experiencing illness, stressing that the fundamental characteristic feature of bodily illness – pain, is a psychological phenomenon. “Neither minds nor bodies suffer from diseases. Only people (or, in a wider context, organisms) do so, and when they do, both mind and body, psyche and soma, are usually involved “ (Kendell 2004: 41). Besides, he calls out Szasz on his selective approach while discussing the necessity of the existence detectable markers of bodily abnormalities for identifying something as illness.

Like all skillful polemicists, Dr Szasz has always been careful to avoid raising issues that might undermine his arguments. He never discusses whether tuberculosis, small pox, malaria and typhoid were diseases before their underlying pathology was elucidated, and whether physicians were justified in striving to treat them before the causal organisms were identified. Nor does he ever discuss whether conditions other than mental disorders that are still defined by their syndromes – migraine, for example, and movement disorders like essential tremor, torticollis, blepharospasm, and torsion dystonia – are justly regarded as diseases. Presumably, this is because he recognizes like everyone else that the obvious suffering and disability associated with these conditions is at least *prima facie* evidence that they should be regarded as diseases, and that physicians are not only justified in trying to treat them but under an obligation to do so. (Kendell 2004: 33)

Both Kendell and Szasz seem to agree that term mental illness does bear a negative connotation, with a historical tie of its archaic significance. However, the solutions they offer for this particular problem greatly differ from one another. Kendell indicates on the evidences, that there is a biological dysfunctions underlying for the most of mental disorders and vice versa and notes out that psychiatry faces the dilemma of finding a better term, which would not imply such a stigmatizing distinction between mental and physical disorders. “If we do continue to refer to “mental” and “physical” illnesses we should preface both terms with “so-called”, to remind both ourselves and our audience that these are archaic and misleading terms” (Kendell 2004: 46). As for Szasz, even

thought he does not deny the existence of brain abnormalities, has no intention to connect the brain functioning with the mental illnesses, which are diagnosed by means of clinically recognizable set of symptoms. That is, for Szasz brain diseases are strictly brain diseases and mental diseases are not diseases at all (Szasz 1976: 110).

The discussion over the validness of mental illnesses seems to come down to the pure semantics. Precisely, before deciding whether mental illnesses exist or not, it seems logical to put the question of how do we understand illness in the first place, as the very perspective of approaching illness may change the whole course of debate.

As much as Szasz makes some interesting points that may deserve careful reflecting, he tends to make the flat statements based on his own subjective understanding of illness, of course supported by the definitions of it, suitable with his outlook. Likewise, his opponents object the view that mental illness does not exist, considering their own understanding of the concept of illness. Approaching the problem in a dialectical way makes plain to see that reaching the conclusion is impossible unless both sides have the same underlying understanding of the concept they have a debate over. That is, syntactically both opponents speak of the same thing, but semantically they discuss different notion. It may remind us of a curious situation whereas two persons would arguing over the value of an apple, one having in mind an actual fruit and another thinking about the brand of techniques.

Following, if we approach a disease as referring to a bodily lesion only, we concur that a mind as the tangible organ does not exist, in which scenario Szasz appears to be right dismissing the essence of mental illness. However, if we look at the illness as a subjective experience of unwell and suffering, the picture changes. Moreover, in this sense, Szasz is no different from the psychiatrists he criticizes for diagnosing individuals with illnesses based on their subjective perspective, as he himself assumes a role to set an anti-diagnosis and decide that people do not have these illnesses.

Not to engage in the discussions asserting the validness of mental illnesses on the biological and genetic level, which is the topic of a broader work with a different main focus, whole debate can be perhaps broken down to the simple statement. That is, if a

person identifies and conceptualizes the own subjective experience as an illness, analyzing and treating of the outcomes should be the main concern for everyone involved, rather than questioning the validness of illness, based on whether its signs are visible or perceivable.

1.2.2. The Shift Between Normal and Pathological

Discerning normal from pathological and drawing a line between these two is the central concern to the topic of mental health. Initially, in its essence to identify one's cognitive-behavioral pattern as deviating from norm, a mental illness diagnosis is built on such a differentiation.

As may be seen below, the distinction between normal and abnormal is not as clear-cut as it may seem. In truth, due to its subjectivity the topic demonstrates great deal of ambiguity. Generally speaking, what is accepted as normal behavior in one society can be deemed strange and eccentric in another. If we break this issue down to the individual perceptions of normality and abnormality the picture becomes even more chaotic. In brief, the line between normal and abnormal is very imprecise as there is no universally understood and accepted definition of these notions. One may fairly ask then, how valid the categorization of pathological conditions can be if there exists no precise definition of normal behavior itself.

Respectively, while philosophically speaking we cannot designate the essence of normality, being the members of certain societies we encounter with its definitions in different areas of life. The members of the society need to agree on the fundamental rules of normal behavior to function as a society and not let the chaos taking control. However, the topic requires more sophisticated and careful approach when it comes to distinguishing normal from pathological in regards of making a psychiatric diagnosis. American researcher psychologists have given an account of the different perspectives of understanding abnormality, conducive to qualify a behavior as abnormal.

The simplest way to define abnormal behavior is in terms of *norm violation*. Each society has a set of **social norms** – rules that prescribe “right” and “wrong” behavior – by which its members live. [...] Another way to define abnormal behavior is in terms of its statistical rarity. *Using statistical abnormality* as a standard, we consider people abnormal when their behavior differs greatly from that of the majority (the “average”). [...] Less restrictive than norm violation or statistical rarity is the standard of *personal discomfort*, which is based on an individual’s self-assessment. According to this definition, only those who are distressed by their own thoughts or behavior are abnormal. [...] A fourth definition is the standard of *maladaptive behavior*. If a physically healthy person cannot hold a job, deal with family and friends, or get out of bed in the morning, most of us would agree that he or she is psychologically disturbed. [...] Finally, we can define abnormality in terms of its *deviation from an ideal*. (Bootzin, Bower, Crocker, Hall 1991: 534-535)

Authors accentuate the flaws of each perspective, stating that none of them alone is perfect, thus concluding that all the methods should be taken into account while categorizing an abnormal behavior. It can be plain to grasp the philosophically challenging problems presented by such viewpoints as understanding abnormality in terms of *norm violation*, *statistical abnormality* and *deviation from an ideal*. The first one grants authority to socially accepted standards of normality, which are changeable and different in every society. For another, the notion of an average person is the bottom line, which is also a very unsteady and variable ‘unit of measurement’ of normality, as what is considered average today may become abnormal tomorrow and the vice versa. An uncertainty of an idealistic and utopian approach presented in the last perspective can be already seen from its definition, as the notion of ideal is same way and perhaps even more subjective as the notion of normal. As for the problems presented by *maladaptive behavior* perspective, authors point out that such understanding comes also across the issue of subjectivity.

The major disadvantage is that “adaptive behavior,” like normality, is subjectively defined and difficult to apply as a consistent standard. Germans who cooperated in the genocidal programs of the Nazi regime had adapted to the demands of their society; their behavior would be considered “adaptive”, despite being morally objectionable. (Bootzin, Bower, Crocker, Hall 1991: 535)

Following, the least socially standardized way to understand abnormality, in terms of having a mental disorder, is to leave the right of judgment to the first person. Evidently, if we want to free ourselves from the socially constructed implications of what is normal and what is pathological, the subjective experience of unwell is what becomes of

importance as an underlying concept to approach the topic. However, this outlook is also criticized by the same authors, pointing out the problem of the diversity in regards of different individual's understanding of their conditions.

This standard is also faulty, primarily because the same behavior patterns can make one person miserable but bother another only a little. In fact, some people (schizophrenics, rapists, and murderers, for example) may be violent or dangerous and not feel any distress at all. Limiting the definition to personal discomfort, then, gives us no yardstick for evaluating any specific behavior (Bootzin, Bower, Crocker, Hall 1991: 535)

Seemingly, the above-cited argument is written from the psychiatric standpoint and the clinicians are sound in their concern on too much individualization regarding the understanding of pathology. Outlining that the cold-blooded murderers, who do not feel any discomfort for their actions, cannot stand for the valid sources in defining specific behavior as normal or abnormal is also very much understandable. However, the point seems to be somewhat inaccurate. The example includes other highly stigmatizing aspect, such as listing “schizophrenics, rapists, and murderers” in the same context, while there is no evident relationship between the murderers, rapists and patients with schizophrenia. Optimistically, stigmatizing of the people with mental illnesses was not the very intention of the authors. Seemingly, their motive was to make a point regarding the imperfection of *personal discomfort* perspective alone, as any other outlook listed. However, provided example catches the eye of a reader, since it places a person with mental illness among the highly dangerous criminals.

To leave aside the stigmatizing aspects and follow the logic of the content itself, it must be mentioned, that the distinction should be made between mental illness, abnormal behavior and criminal behavior. Logically speaking, while some of the rapists and murderers may actually be diagnosed with some kind of mental illness including schizophrenia, it does not by any means mean that all of them are. Likewise, while some people diagnosed with schizophrenia may be violent and dangerous, it does not mean that so are all of them. On the other hand, the murderers and rapists listed next to “schizophrenics”, are violent and dangerous being murderers and rapists in itself. For recognizing and treating the latter there exists a criminal code and DSM should not be concerned with it and perhaps neither should bring it as an example while discussing

abnormality in terms of mental disorders.

Following, as we differentiated mental illness and criminal behavior, the argument of murderers and rapists not feeling discomfort for their actions can be disregarded in regards of mental health. The next and more challenging distinction to be made takes place between the mental illness and abnormal behavior. For this sake, first we can have a look at the modern diagnostic ways of distinguishing one from another. Typically, the usual case of diagnosing a physical illness consists of the certain stages. A doctor must first examine the problem, which involves asking questions to the patient and providing medical inspection of the problematic body area. Depending on the obscurity of the situation different analysis and surveys can be conducted to set the correct diagnosis and offer the right treatment afterwards.

Likewise, the patients with mental illnesses usually report their symptoms to the psychiatrist, who using the variety of assessment tools and evaluating the degree of functional impairment come up with the particular diagnosis. However, unlike physical illnesses, the process of diagnosing individual with a mental disorder can be considered as more of the subjective operation, given that the presence of mental illness is not usually detected by the laboratory tests. In their way of making a diagnosis, psychiatrists use a variety of assessment measures, such as clinical interviews, personality tests, behavioral and cognitive assessment tests, assessment of stress and intelligence tests. “The data from the various techniques complement each other and provide a more complete picture of the person. In short, there is no one best assessment measure. Rather, using multiple techniques and multiple sources of information will provide the best assessment” (Kring, Johnson, Davison, Neale 2010: 74). Besides the psychological assessment methods, clinicians also turn to neurobiological assessment modes, such as brain imaging, neurotransmitter assessment, neuropsychological assessment and psychophysiological assessment. These methods help mental health professionals to have a close look at the structure and functioning of the brain linked to the behavioral or cognitive problems experienced by the patient, as well as enable them to observe the bodily changes such as tension in the muscles and increased heart rates linked to the psychological events. Finally, to set the precise diagnosis, psychiatrists use diagnostic

manuals providing the classification and definitions of mental disorders, making it possible to determine whether the condition of a person fits to particular diagnostic criteria.

Seemingly, from the standpoint of mental health professionals, the specific behavioral and cognitive patterns identifiable in certain patients are already qualified as abnormal, being categorized in agreed-on diagnostic manuals of mental disorders. However, clinicians clarify that a presence of the corresponding symptoms is not enough for making a mental disorder diagnosis, but they should be causing a severe personal distress or dysfunction whether in interpersonal relationships or academic and job-related areas of life. “The DSM specifies that symptoms alone are not enough to qualify for diagnosis. Rather, a person must experience either impairment or distress to meet criteria for diagnosis” (Kring, Johnson, Davison, Neale 2010: 72). This statement logically leads us to the conclusion that what is qualified as illness is not behavior deemed abnormal and disordered, but the distress caused by them.

On these grounds, it can be stated that the behavior and way of thinking, feeling or relating itself is not an illness regardless how deviating from the commonly accepted norm it is, but the experience of functional disability and emotional anguish is what can be qualified as such. Given this orientation, the pain derived whether from emotional or physical condition can be comprehended as illness, as long as we understand illness as the subjective experience of suffering. This again bring us back to the point mentioned in the previous subchapter, that it is a human being as a whole who suffers while experiencing illness, neither the body, nor the mind separately. Following this way of thinking, the core argument of Szasz’s radical statement that a mental illness does not exist, as there is no such organ as mind, can be undermined. One cannot sound profound stating that something is X or is not X, unless X is entirely and universally definite, leaving no room for alternative reasonable approaches.

Furthermore, speaking of the illness as a subjective experience of suffering, several questions may arise here. For instance, one may ask what happens if a person has a false belief of being ill, such as the case of hypochondria, or opposite – if the person does not

believe he or she has illness, while medically speaking they are diseased. Since we are speaking from the position of the individual experience, the state of mind called hypochondria can be understood as illness. In fact, such a condition makes a person worried about their health, which they believe is in danger. Following, regardless the fact that biologically speaking, there may not be any presence of illness, if a person does suffer and experiences distress from own beliefs, this in itself fits into category of illness that is understood as experience of suffering. For empowering this argument, an example of the dead person can be brought. From the purely organic point of view the dead body is experiencing progressive illness, as its organs get rotten. Certainly, no one thinks of the dead body as diseased, simply because it is dead. What is missing is a perception of the person, the subjective experience of suffering from the own body getting rotten. On these grounds, speaking from individual point of view it can be concluded that without the subjective experience of illness, there is no illness and if there is the subjective experience of illness, it can be comprehended as such.

French philosopher and physician Georges Canguilhem has given a valuable account on the topic. In his work *Normal and Pathological*, Canguilhem opposes the mechanistic views on the human medicine, reducing it to the mere organism, not taking into account any other meanings of human life, but strictly biological. He brings to our attention the importance of expanding the horizon in terms of distinguishing normal and pathological conditions.

In order to evaluate the normal and the pathological, human life must not be limited to vegetative life [...] Man, even physical man, is not limited to his organism [...] Thus, in order to discern what is normal or pathological for the body itself, one must look beyond the body. (Canguilhem 1991: 200-201)

Indeed, a deeper understanding of the subject requires taking into account the complex interrelation of a body and a mind all coming down to a person's perceptions and experiences of oneself, rather than limiting the problem to the bodily organs. Interesting aspect to mention here is that, while posing the question of the individuality, Canguilhem does not refer to mental illnesses specifically, but to all kinds of diseases that are concern of physiology. On the ground that norm cannot be scientifically defined, he suggests (Canguilhem 1991: 203) that neither disease can be so defined, rather it can be

understood as another kind of norm. On the same logic, he argues that there is no purely scientific and purely objective understanding of pathology and it can only have a clinical value. However, he explains that in their position of fighting for life and health, a physician can qualify the condition as pathological.

It is life itself, through its differentiation between its propulsive and repulsive behavior, which introduces the categories of health and disease into human consciousness. These categories are biologically technical and subjective, not biologically scientific and objective. Living beings prefer health to disease. The physician has sided explicitly with the living being, he is in the service of life and it is life's dynamic polarity which he expresses when he speaks of the normal and the pathological. [...] the distinction between physiology and pathology has and can only have a clinical significance. This is the reason why, contrary to all present medical custom, we suggest that it is medically incorrect to speak of diseased organs, diseased tissues, diseased cells. (Canguilhem 1991: 222-223)

Canguilhem further concludes that illness is a subjective experience of a living being as a whole, not the specific condition of body parts, which is very much in agreement of what has been argued above.

We do not mean that a cell cannot be sick if by cell we mean an entire living thing, as for example a protist [unicellular organism], but we do mean that the living being's disease does not lodge in parts of the organism. [...] We suggest that it is the whole that it can be called sick or not. (Canguilhem 1991: 223-224)

1.2.3. Interaction with the Label

Dealing with the 'constructed' and 'real' distinction, it becomes of importance to distinguish between the illnesses as identified or as the fellow critics of psychiatry would say 'invented' and our ideas about them. For example, the concept of being a woman is definitely socially constructed with the various associations attached to it. However being a woman is also a natural condition for those who were born as female. The general ideas regarding how should a woman behave or what distinguishes her as a social being from another kind of social being - a male, are also purely subjective and oftentimes discriminating beliefs build up by the society, differing from culture to culture.

Likewise, a person identifying oneself having a mental disorder acknowledges the

realness of their illness considering how the specific symptoms manifest themselves. The illness in a sense of being categorized and labeled by the psychiatrists is constructed. The ways of how the illness is perceived is certainly socially constructed as well. However, the distress connected to this illness experienced by the person remains real. For instance, a person having no name for her lung cancer would feel exact same horrible pain as one being aware of her illness. Similarly, not having a name and place in the diagnostic manuals would not change one's painful feelings going through the mental struggle. However, being aware of having a lung cancer may give a birth to additional feelings about oneself. Likewise, since having a place in the diagnostic manuals provides the label for the group of people fitting into the category, it may provoke further conceptual changes in the mind of a person.

Following, the question of whether creating a name for something implies creating its context as well may arise here. Apparently, to name the illness, first there should be a set of symptoms manifesting itself in the practice. On the other hand, the very moment of giving the name to these symptoms can be understood as a moment of creating additional context for the future. That is, the meanings attached to the condition, officially coming along the label.

Dealing with the real-constructed dilemma of mental illness, in his successful attempt to take the middle-ground Ian Hacking speaks about the importance of approaching the topic more comprehensively, rather than stating that X is real or X is constructed.

‘Social construct’ and ‘real’ do seem terribly at odds with each other. Part of the tension between the ‘real’ and the ‘constructed’ results from interaction between the two, between, say, child abuse, which is real enough, and the idea of child abuse, which is ‘constructed.’ But that is not all. We can also confuse more complex types of interactions, which make some people think of antique dualisms between mind and body. These come out most clearly when we turn to the very habitus of mind and body, psychopathology. Most present-day research scientists take schizophrenia to be at bottom a biochemical or neurological or genetic disorder (perhaps all three). A minority of critics think that in important ways the disease has been socially constructed. I do not want to take sides, but to create a space in which both ideas can be developed without too much immediate confrontation—and without much social- construction talk either. (Hacking 1999: 101)

Hacking further introduces the notion of interactive kind of classifications and

differentiates them from indifferent kinds. According to him, interactive kinds are the categories capable to establish the mutual interaction with people classified. That is, on one hand, classified kinds may influence those who fall into the category and herewith being the subject of scrutiny, are going under the continual developing and modification themselves.

"Interactive" is a new concept that applies not to people but to classifications, to kinds, to the kinds that can influence what is classified. And because kinds can interact with what is classified, the classification itself may be modified or replaced. [...] Kinds that are the subject of intense scientific scrutiny are of special interest. There is a constant drive in the social and psychological sciences to emulate the natural sciences, and to produce true natural kinds of people. (Hacking 1999: 103-104)

As for the indifferent kinds, in contrast of interactive kinds, being placed in this class does not make any difference for those classified. What Hacking indicates here on, is that a gemstone is indifferent towards out classification of it as a gemstone, while someone aware of own label is not. That is, acknowledging the own place in the classified kinds implies an interaction with it, including rethinking oneself. Clearly, types of classifications can be applied to mental disorders. More precisely, mental disorders can be approached through the prism of either interactive or indifferent kinds, depending on the subjective perspective of understanding them.

The clinician who takes a psychological approach may seem to regard an illness as interactive; one who takes a biological (e.g. chemical) approach does seem to regard it as indifferent. If you subscribe to the predisposing/occasioning model of a mental illness, the predisposing cause may be biological, indifferent, while the occasioning cause may be social, interactive. (Hacking 1999: 119)

The important implication of Hacking's account is that it offers the prospect of approaching mental disorders in a more inclusive way. Instead of taking sides determined by subjective perspective and making radical statements, it makes possible to take into account different aspects of the subject matter. Applying the interactive kinds of classification to the essence of mental disorders does not abolish its place among the indifferent kinds of illnesses. A person aware of their disorder is likely to get influenced by the interaction with their label in a number of ways. However, one cannot be sound in stating that not knowing their diagnosis the same person would not be suffering.

Furthermore, Juri Lotman in his article *Culture As a Subject and an Object Itself* uses the term *monad*, standing for a meaning-generative unit that exists within the semiotic space. Lotman notes (1997: 9) that such monads are definite, self-sufficient and bear not material, but semiotic-informational value, providing both ‘input’ and ‘output’ between the unit and its outside semiotic space. It seems possible to draw some parallels between the monads discussed by Lotman and the labels of mental disorders. Indeed, such labels are meaning-generative by their nature and bear semiotic-informational value. Moreover, the process of producing ‘input’ and ‘output’ seems to be the focus of Hacking’s analysis while speaking of mutual interaction between people and their classifications. Lotman further elaborates on the topic and explains the purely semiotic nature of monads, from where some insights can be drawn regarding the capacity of labels to produce new meanings and store this information into memory.

I have already mentioned that the monad is a generator of new messages, i.e. messages not constructed by automatically operating algorithms. In other works I have already pointed out its ability to store the information received, i.e. memory. I should also note that informational exchange and blending of texts takes unceasingly place within the semiosphere. This is granted by the structural isomorphism of monads, their integration into metalanguage communities, those communities where some kind of unified level of semiosis is being established. The presence of all these qualities permits us to define the semiotic monad as an intellectual unit, a bearer of the mind. (Lotman 1997: 12)

Finally, Lotman himself “with certain caution” links monads to the concept of personality.

[...]a parallel could be established between the semiotic monads and the concept of personality, since behavioral autonomy is to some extent also characteristic to semiotic monads. [...] A monad as a part of a unity is governed by strict laws of determination, whereas as a whole, as a “personality”, it has the possibility to choose and a certain reserve of freedom, autonomy from the whole, and its own semiotic context. (Lotman 1997: 13-14)

In this context, the relationship of the person and their label can be somewhat crystallized by noting that, a label as a definite meaning-generating mechanism, in case of becoming the dominant part of a personality, turns an indeterminacy into the object of limitations. For instance, the label of the BPD diagnosis may serve as a generator of new meanings attached to self, considering the meanings attained by the label itself. In terms of being

classified in the interactive kinds discussed by Hacking, a person with BPD may get influenced by the significance of the classification, covering the group of individuals with a shared diagnosis. In this process, a personality “that has the possibility to choose” may become somewhat reduced to the way it is classified, that is the definite label may attain the control over the infinity of a personality. However, the further analysis shall show that the process of forming such a synthesis is more complicated taking into account a person’s primary self-description.

2. Borderline Personality Disorder As it is Known

The following chapter provides a descriptive analysis of borderline personality disorder, based on the existing psychiatric and scholarly knowledge of it. The chapter aims to shed the light on the major aspects linked to the diagnosis. The analysis is based on the criteria presented by the most recent edition of *Diagnostic and Statistical Manuals of Mental Disorders of American Psychiatric Association*.

Borderline personality disorder is known as a severe form of psychopathology, mostly occurring by early adulthood. The disorder is essentially characterized by extreme intensity of emotions, impulsive and self-destructive behavior and identity disturbance. The condition poses a great deal of questions for the researchers. Even the name of the diagnosis is filled with uncertainty. The term does not really clarify what exactly does it signify, rather causes pure confusion. Hearing the name of the disorder leads to the valid question – ‘borderline between what and what?’ The possible answers can range from borderline between sanity and insanity to borderline between mania and depression and so forth. Logically, an imprecise term creates a large room for interpretations. However, as we shall see, the name of the disorder is not the only confusing element of the condition. Heterogeneity of symptoms linked with BPD and comorbid nature of the disorder make the condition fairly complex and difficult to spot and treat for the mental health professionals.

The first part of the chapter takes a close look at the history of BPD and its present diagnostic criteria. The following section overviews the essential features and major symptoms linked with borderline personality disorder. The last two sections focus on the etiology of the condition and the causes of the stigma attached to it.

2.1. BPD from 30s to the Present Day

2.1.1. Historical Considerations

Considering the growing number of people getting the diagnosis of BPD, one may assume the condition is a present day illness. However, a large part of the clinicians believe that it is a professional awareness about BPD what is growing, rather than number of patients. In this respect, the label itself can be called new, but not the condition.

Most psychiatrists believe that the borderline syndrome has been around for quite some time; that its increasing prominence results not so much from its spreading (like an infectious disease or a chronic debilitating condition) in the minds of patients but from the awareness of clinicians. Indeed, many psychiatrists believe that some of Sigmund Freud's most interesting cases of "neurosis" at the turn of the century would today be clearly diagnosed as borderline. (Kreisman, Straus 2010:19)

The psychoanalyst Adolf Stern was the first who described the symptoms included in the present diagnostic criteria for BPD. Furthermore, it was Stern who coined the term 'borderline', in 1938. He so named the condition of patients who were believed to lie on the border between neurosis and psychosis. Patients labeled by Stern, did not seem to fit well within the diagnostic classification system of that time. Exhibiting mixture of symptoms of both neurosis and psychosis, they seemed to be more ill than neurotics but not exactly psychotic. They exhibited difficulties with perceiving reality and were standing out from the rest of patients as hypersensitive and very difficult to treat, creating trouble for the clinicians.

Psychopathology at that times was conceptualized as occurring on a continuum from "normal" to "neurotic" to "psychotic." Stern labeled his group of outpatients as suffering from a "borderline group of neuroses." For many years thereafter, the term was used colloquially among psychoanalysts to describe patients who, although they had severe problems in functioning, did not fit into other diagnostic categories and were difficult to treat with conventional analytic methods. (Linehan 1993: 5)

As the number of patients fitting into new unfitting category was growing, the condition attracted the major attention of the contemporary psychoanalysts. Several scholars have tried to contribute in the research of the new phenomenon during the 50s.

Knight (1954) presented a definitive statement of the term borderline. [...] Wolberg (1952) distinguishes the borderline from the psychotic even though the former may have temporary psychotic-like episodes. [...] Schmidberg (1959) describes the borderline as a syndrome blending normality, neuroses, psychoses and psychopathy in a relatively stable life-long period. (Grinker, Werble, Drye 1968: 11-12)

The very first research on the patients qualified as ‘borderlines’, was conducted in 1968, by Roy Grinker, Beatrice Werble and Robert Drye. The term they used referring to the condition was Borderline Syndrome. Introduction of their book *Borderline Syndrome. A Behavioral Study of Ego-Functioning*, gives a very clear picture of the obscurity, the condition was immersed in at that time.

The borderline diagnosis has not yet appeared in the official American or International Classification of Psychiatric Disorders, or in Stengel’s (1959) extensive survey of existing classifications prepared for the World Health Organization (W.H.O.). It did not appear in the design of the fact-finding program of the American Psychoanalysts Association. There are no statistics on prevalence, the term has no legal meaning and the label does not evoke a stereotype for most psychiatrists. There has been no published systematic study of these patients, and the term is now only part of the jargon of psychiatric practice. (Grinker, Werble, Drye, 1968: 3-4)

The new notion ‘borderline personality organization’, was introduced by Otto Kernberg, offering new clinician insights. He divided mental disorders into three distinct types: psychotic, neurotic and borderline personality organizations.

The term “borderline” should be reserved for those patients presenting a chronic characterological organization which is neither typically neurotic nor typically psychotic, and which is characterized (i) by typical symptomatic constellations; (ii) by a typical constellation of defensive operations of the ego; (iii) by a typical pathology of internalized object relationships; and (iv) by characteristic genetic-dynamic features. (Kernberg, 1975: 5)

Following, major contribution in defining the disorder was made by John Gunderson and Margaret Singer, in 1975, when they published an article in *The American Journal of Psychiatry* (Vol. 132, issue 1, pp.1-10) synthesizing relevant literature review and defining six essential features of the disorder, including emotional intensity, impulsivity, problems with interpersonal relationships and short living psychotic episodes. Later, Gunderson proposed and published research instrument for diagnosing the condition accurately.

Finally, in 1980 the condition got officially recognized as a valid diagnostic entity by the

American Psychiatric Association and entered *DSM III*. Research interest in a newly emerged mental illness began to grow rapidly. The number of the researchers have contributed to explore the nature of BPD in 1980s.

Gunderson (1984) has summarized four relatively distinct clinical phenomena responsible for the continued psychoanalytic interest over the years in the borderline personality. [...] Taken together, these four observations suggested the existence of a group of individuals who did not do well in traditional forms of treatment, despite positive prognostic indicators. [...] In contrast to the single continuum proposed in psychoanalytic thought, biologically oriented theories have conceptualized BPD along several continua. From this viewpoint, the disorder represents a set of clinical syndromes, each with its own etiology, course, and outcome. Stone (1980, 1981) has reviewed this literature extensively and concludes that the disorder is related to several of the major Axis I disorders in terms of clinical characteristics, family history, treatment response, and biological markers. For example, he suggests three borderline subtypes: one related to schizophrenia, one related to affective disorder, and a third related to organic brain disorders. [...] A third approach to understanding borderline phenomena has been labeled the “eclectic-descriptive” approach by Chatham (1985). A fourth approach to understanding borderline phenomena, based on a biosocial learning theory, has been proposed by Millon (1981, 1987a.). (Linehan 1993: 7-10)

However, as we shall see the clinicians still struggle to identify an exact nature and causes of the disorder and people labeled by the BPD diagnosis still experience the stigma coming not only from the general public, but in many cases from the mental health professionals as well.

2.1.2. Diagnostic Manuals of BPD

Borderline personality disorder is one out of the ten personality disorders listed in the fifth edition of *DSM* of *American Psychiatric Association*. The *DSM* defines personality disorders as “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (APA 2013: 645). In this sense, personality disorders differ from other kind of mental illnesses, such as mood disorders, which are considered as conditional and usually responsive to the medication. BPD is placed in the cluster B (group of dramatic, emotional and erratic personality disorders) together with antisocial, histrionic and

narcissistic personality disorders. The symptomology of BPD is very wide in range. Among the features linked to the disorder can be found extreme and brief mood swings, black and white (polarized) thinking, splitting (idealization and devaluation cycles), chronic feeling of emptiness, no clear sense of self-image, chaotic interpersonal relationships, paranoid ideation, uncontrollable rage, inability to control impulses, substance abuse, self-harm and suicidal behavior.

The diagnostic criteria of borderline personality disorder presented in the most recent *DSM-V* consist of nine categorical symptoms. (APA 2013: 663) A person gets BPD diagnosis if she meets five or more out of nine symptoms listed below.

1. Frantic efforts to avoid real or imagined abandonment. (Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.)
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self-image or sense of self
4. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). (Note. Do not include suicidal or self-mutilating behavior covered in criterion 5.)
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

Despite its prestigious position to be considered as a psychiatric bible, *DSM* criteria still is a topic of discussion among those concerned with mental health problems. There is an ongoing debate among the researchers discussing whether the current criteria are effective in identifying the disorder. Some researchers argue that replacing the structural and categorical manuals with more dimensional approach to diagnosis would be beneficial to better treat mental health patients.

Some researchers have suggested adjusting the DSM to a dimensional approach to diagnosis. Such a model would attempt to determine what could be called “degrees of borderline,” since clearly some borderlines function at a higher level than others. These authors suggest that, rather than concluding that an individual is – or is not – borderline, the disorder should be recognized along a spectrum. (Kreisman, Straus 2010: 9)

One may argue that structured paradigm presented in *DSM* does not require changes and measurement whether a patient is more highly functioning or low functioning should not necessarily be included in the criteria, but can be addressed in the treatment process. Certainly, structural categorization of symptoms can be an efficient way for mental health professionals to evaluate whether someone is qualified as borderline or not. Yet, some questions may arise regarding the present method of diagnosing BPD.

As it was mentioned above, for the BPD diagnosis it is required five or more symptoms out of nine to be present. What creates confusion here is the question of what happens if the person exhibits not the minimally required five but only four traits out of nine. For instance, one may have serious suicidal tendencies, may experience impulsivity in all areas listed in the criteria, may struggle with difficulty to control intense anger and have massive problems with interpersonal relationships due to her tendency of idealizing and devaluating others. Apparently, person would manifest four of the essential BPD traits recognized as such, making their life difficult enough to reach out for help. However, as *DSM* suggests, they would not be diagnosed with BPD due to the fact that one more criteria would be missing from the whole picture.

One more important aspect to reflect on here is that obviously, everyone from time to time may experience some of the traits listed in the BPD and perhaps any other personality disorder criteria. One may act impulsively and regret her actions afterwards, explode with anger during the stressful period, feel empty and bored, experience confusion about their true identity and so forth. Certainly, it does not mean one automatically is qualified as someone having borderline personality disorder. Apparently, all the features listed, regardless how extreme some of them may seem, are part of human behavior. We can hardly find a person presenting only healthy qualities, as the human nature implies in itself having the mix of both healthy and unhealthy traits. As mental health professionals clarify and as it was discussed in the previous chapter, the question

of having a personality disorder is put on the table when the disordered traits reach a level of frequency and rigidity, causing a functional impairment. To put it differently, unhealthy traits cease being just unhealthy traits and become personality disorder elements when they form fixed pattern of behavior, thinking and relating, widely affecting one's interpersonal and intrapersonal functioning.

2.2. 'Stable Unstable, Predictably Unpredictable' - Essential Features of BPD

2.2.1. Emotional Intensity and Instability

Marsha M. Linehan, Professor of psychology and adjunct professor of psychiatry and behavioral sciences at the University of Washington in Seattle, has significantly contributed in enrichment of borderline personality disorder theoretical scholarship. Moreover, she is an author of the Dialectical-Behavioral Therapy (DBT), which nowadays is known as one of the first choices of treatment for those with BPD. In her interview with *Time Magazine* (2009) Linehan describes patients with BPD as individuals who lack emotional skins. "Borderline individuals are the psychological equivalent of third-degree burn patients. They simply have, so to speak, no emotional skin. Even the slightest touch or movement can create immense suffering. "

As determined, emotional intensity and high level of sensitivity is one of the core features of borderline personality disorder. Following, having BPD implies having a trouble with regulating emotions and as described by clinicians and patients themselves, experiencing the highest highs and the lowest lows. Emotional reactions to the events of those with BPD are qualified as out of proportion of the events they response at. That is, whereas the healthy person would have an average reaction on a particular trigger, emotional response of someone with BPD would be much more extreme. Meaning, whereas a healthy person would feel sad, an individual with borderline personality disorder would feel devastated.

Besides emotional intensity, people with BPD are identified as emotionally unstable. In fact, instability is an essential hallmark of the condition. ‘Stably unstable and predictably unpredictable’ as referred by clinicians, patients with borderline personality disorder tend to experience extremely rapid and unpredictable mood changes characterized as very intense and brief. Following, someone with BPD may go through the mood changes cycle multiple times in a course of the single day, rapidly shifting from the heights of happiness to depths of despair, from severe depression to true euphoria. Researches link this symptom with the tendency of misdiagnosing people with BPD with bipolar disorder, the core feature of which is such a radical fluctuation of moods. However, clinicians explain that unlike bipolar disorder where these mood shifts last for days, weeks or months, people with borderline personality disorder cycle much more quickly. Besides, as explained, mood cycles in bipolar patients are caused by neurological chemical imbalance, while BPD mood shifts are known to be responsive to the outside stimuli and triggers.

Following, people diagnosed with borderline personality disorder are deemed difficult to establish and maintain close and healthy relationships with. As defined, individuals with BPD tend to think in two extremes. That is, they perceive everything as either black or white, with no grey area in between. Dichotomous thinking applies to their perception of self as well as approaching others, manifested by the constant alternation between two extremes of idealization and devaluation. The term used by the clinicians to depict this feature is ‘Splitting’. The term suggest that patients with BPD may perceive someone close to them as entirely good and wonderful one moment and switch to seeing them as utterly bad and awful the next.

Technically defined, splitting is the rigid separation of positive and negative thoughts and feelings about oneself and others; that is, the inability to synthesize these feelings. Most individuals can experience ambivalence and perceive two contradictory feeling states at one time; borderlines characteristically shift back and forth, entirely unaware of one emotional state while immersed in another. (Kreisman, Straus 2010: 14)

Another BPD related symptom affecting interpersonal relationships, is the fear of abandonment. As clinicians point out, such a fear may push an individual with BPD to take the frantic measures in order to avoid being abandoned. Person may begin pushing

away her loved ones to test how deep the loyalty runs. She may sabotage the closest relationships and leave the loved ones first out of the fear of abandonment. One more feature linked to the condition is explosive attacks of anger over the trivial matters, making interpersonal communications highly difficult.

2.2.2. Impulsivity and Self-Harm

Impulsive and self-destructive behavior is another hallmark of borderline personality disorder. As characterized, people with BPD repeatedly engage in self-damaging behavior without considering possible outcomes. Most commonly, these actions involve reckless driving, uncontrollable eating, gambling and spending, substance abuse and sexual promiscuity. As reported by the clinicians, substance abuse and eating disorders are highly common among the people having BPD.

Numerous studies have linked BPD with anorexia, bulimia, ADHD, drug addiction, and teenage suicide—all of which have increased alarmingly over the last decade. Some studies have uncovered BPD in almost 50 percent of all patients admitted to a facility for an eating disorder. Other studies have found that over 50 percent of substance abusers also fulfill criteria for BPD. (Kreisman, Straus 2010: 8)

Patients with borderline personality disorder are described as people having a very hard time controlling their impulses. Once the particular impulse hits, it is felt as an immediate need, which has to be met. As psychologists explain, impulsive and risky behavior serves as a coping mechanism with the chronic pain and turbulence of emotions they experience and an attempt to fill the chronic emptiness. “After they engage in an impulsive act, they usually report feeling momentarily better. However, those feelings of satisfaction are quickly replaced by enormous guilt, anxiety, and self-loathing” (Elliot, Smith 2009: 68).

More extreme of self-damaging behavior related to the condition is self-harm, a very common trait among those diagnosed with borderline personality disorder. The self-harm behavior ranges from cutting, scratching and burning skin to hair pulling and head banging. These actions usually do not aim suicide and are used for different reasons by those qualified as borderlines. One of the most common reasons of hurting own body

pointed out by clinicians is an attempt to distract self from emotional pain. Some of the patients with BPD describe their internal pain unbearable to the extent that they need to reduce overwhelming emotional discomfort by virtue of causing the physical pain. Another common reason named is to fight emotional numbness, trying to 'feel something'. Some report using self-harm as a punishment act, believing they deserve the pain.

As many as 75 percent of borderlines have a history of self-mutilation, and the vast majority of those have made at least one suicide attempt. [...] For these borderlines, the body becomes a road map highlighted with a lifetime tour of self-inflicted scars. Razors, scissors, fingernails, and lit cigarettes are some of the more common instruments used; excessive use of drugs, alcohol, or food can also inflict the damage. Often, self-mutilation begins as an impulsive, self-punishing action, but over time it may become a studied, ritualistic procedure. (Kreisman, Straus 2010: 46)

Furthermore, suicidal behavior is a fundamental concern in BPD. Patients with borderline personality disorder are identified as the major risk group for suicide. As clinicians state, risk of the suicide remains being high throughout the life cycle, while many of other BPD symptoms tend to decrease and settle down over time.

As many as 70 percent of BPD patients attempt suicide, and the rate of completed suicide approaches 10 percent, almost a thousand times the rate seen in the general population. In the high-risk group of adolescents and young adults (ages fifteen to twenty-nine), BPD was diagnosed in a third of suicide cases. [...] Although many of the defining criteria for BPD diminish over time, the risk of suicide persists throughout the life cycle.²⁹ Borderlines with a childhood history of sexual abuse are ten times more likely to attempt suicide. (Kreisman, Straus 2010: 35; 46)

2.2.3. Identity Disturbance

Another central feature of borderline personality disorder is lacking a core sense of identity. Clinicians report that most of the patients with BPD are not capable to draw a clear picture of who they are, but tend to bear very vague and oftentimes contradictory understanding of self. Following, people with BPD frequently adapt different roles and rapidly transform based on the situations and environments. Instability and unclearness of self-concept results in frequent changes of physical appearance, preferred values, circles of friends, long-term education and career goals.

As follows, chronic feeling of emptiness is linked with the identity-disturbance among the patients with BPD, which in its turn is linked with impulsive and self-destructive behavior.

Many people with BPD report feeling painfully empty inside. They have cravings for something more, but they can't identify what that something more is. They feel bored, lonely, and unfulfilled. They may attempt to fill their needs with superficial sex, drugs, or food, but nothing ever seems truly satisfying — they feel like they're trying to fill a black hole. (Elliot, Smith 2009: 30)

Furthermore, among the symptoms of BPD are listed paranoid ideation and brief quasi-psychotic moments. That is, at times an individual with BPD may be convinced that they are in a serious danger and someone is after them, as well as experience being out of touch with the reality and self, . As explained, such experiences of paranoia, dissociation and depersonalization are brought on by the stressful situations. While dissociating, perceptions of a patient may get severely distorted, involving all of the five senses. Clinicians distinguish psychotic and paranoid episodes of patients with BPD from those experienced by individuals with psychotic illnesses, outlining that former tends to be brief and transient, usually disappearing after the stressful situation is passed.

The borderline may become transiently psychotic when confronted with stressful situations (such as feeling abandoned) or placed in very unstructured surroundings. [...] Unlike patients with psychotic illnesses, such as schizophrenia mania, psychotic depression, or organic/ drug illnesses, borderline psychosis is usually of shorter duration and perceived as more acutely frightening to the patient and extremely different from his ordinary experience. And yet, to the outside world, the presentation of psychosis in BPD may be indistinguishable, in the acute form, from the psychotic experiences of these other illnesses. The main difference is duration: within hours or days the breaks with reality may disappear, as the borderline recalibrates to usual functioning, unlike other forms of psychosis. (Kreisman, Straus 2012: 52-53)

Delving into the clinician description of borderline personality disorder features, it can be said that regardless heterogeneity, symptoms seem to be interconnected and in some sense make a logical chain. Like a domino effect, extreme intensity and instability of emotions cause extreme behavioral responses, manifested by impulsive and self-damaging actions. Having no clear self-concept leads to the chronic feeling of emptiness as well as dissociative symptoms. However, some may argue that most of these symptoms can be found in other mental disorders and putting them together can be in a sense forced action to form BPD as a separate, valid diagnosis. Despite this criticism, this

relatively new diagnosis seems to draw the huge attention of the researchers, reinforcing its status as a severe mental illness on its own.

2.3. On the Etiology of Borderline Personality Disorder

2.3.1. Genetic and Biological Explanations

The question of what causes borderline personality disorder is the subject of massive discussion among the researchers, with no clear answer. Recent studies suggest that there is no single reason for developing borderline personality disorder, but the condition evolves due to the interaction of different elements. Clinical theorists believe that BPD is a result of mixture of environmental, biological and genetic factors. That is, genes determine the level of sensitivity towards the environment, while in their turn environmental events influence the brain functioning and development of personality. “BPD represents the end product of this interplay between biological vulnerabilities and environmental influences. As such, we think of it as a highly individualized disorder“ (Hooley, Cole, Gironde 2012: 415).

Several research results indicates that first-degree relatives of borderline patients are ten times more likely to show signs of the disorder than the general public. However, this alone cannot prove the genetic basis of BPD, as family members mostly share the same living environment and have similar childhoods. Following, one may assume that this is environmental factors what raises risk of BPD in such families, not necessarily genetics. The argument is somewhat rebuffed by evidence from the study of identical twins (International archives of medicine, vol. 8. No.56), obviously sharing the same genetic construction, but being adopted into different families. The results indicated that in most cases BPD is predicted by genetic factors. “Torgersen and colleagues finding of a 68% heritability abruptly invalidated the many theories about borderline personality disorder’s etiology that had focused exclusively on environmental causes. It established borderline

personality disorder's credentials as a "brain disease" (Gunderson 2009: 534). However, as explained, it does not mean in a strict sense that BPD, the ready product as such is inheritable disorder.

Rather what are inherited are genes that confer susceptibility to traits that are important features of BPD such as neuroticism or impulsivity. Traits like these are also diagnostically nonspecific. In other words, they may predispose the person to a range of psychiatric problems. This helps explain why rates of comorbidity are so high in those with BPD. (Hooley, Cole, Gironde 2012: 416-417)

Following, number of neurobiological studies conducted, have suggested that brains of individuals with BPD show some structural differences relatively to those having no diagnosis of BPD. For instance, several results of studies have proved that parts of the brain that puts break on emotions as well as are responsible on the impulsivity level are much less active in borderline patients than in healthy people. It is important however, not to overemphasis an importance of these results specifically for the BPD study, since most of the data has been compared to mentally healthy people. While comparing results of brain functioning of patients with BPD with brain functioning of other clinical patients, differences occurred were not that significant.

For example, Brunner and colleagues (2010) reported reduced DLPFC and OFC volumes in BPD patients compared to healthy controls. However, there were no significant differences in the volumes of these brain areas when the BPD patients were compared to clinical controls. Some of the other structural abnormalities observed in BPD patients have also been observed in other disorder. (Hooley, Cole, Gironde 2012: 422)

2.3.2. The Role of Environmental Factors

Developmental theories on the causes of BPD focus on the environmental factors and life events affecting the personality development. A theory that traumatic events of childhood and unhealthy attitude of the parents towards their children dramatically increase the risk of developing BPD is widely supported by the mental health professionals.

When compared to the healthy controls, the early lives of those with BPD featured significantly more parental discord, more parental absences (e.g., mother in the hospital; father in the jail), more physical violence in the family, more experiences of being raised by other relatives or in a foster home, and more sexual abuse during childhood. (Hooley, Cole, Gironde 2012: 419)

Clinicians report that most of the patients with BPD come from the dysfunctional families, have a childhood abuse history, involving both physical and sexual abuse. These findings explain the high prevalence post-traumatic stress disorder (PTSD) among the people diagnosed with borderline personality disorder.

A history of childhood abuse is highly prevalent in adult patients with borderline personality disorder (BPD). In clinical settings, 40% to 76% of adults with BPD report childhood abuse: 25% to 73% report childhood physical abuse (Zanarini, 2000). [...] Documented sexual abuse is associated with elevated BPD symptom levels among young adults seen in community surveys (Johnson, Cohen, Brown, Smailes, & Bernstein. 1999) [...] To some investigators, these associations suggest an etiology role for childhood abuse in the development of borderline psychopathology [...]. (Soloff, Lynch, Kelly 2002: 201-202)

Marsha Linehan further clarifies how the unhealthy environment can affect someone's personality development to the course of BPD. She outlines that in such instances a person usually either leaves the invalidating environment, or tries to meet the expectations of this environment via changing own behavior. "The borderline dilemma arises when the individual cannot leave the environment and is unsuccessful at changing either the environment or her own behavior to meet the environment's demand" (Linehan, 1993: 52).

Overall, clinicians and researchers agree that both clinically and etiologically heterogeneous condition named as BPD seems to be a collisional result of complex life events and genetic vulnerabilities. An interesting aspect to note here is that BPD is mostly diagnosed in women. This gave a rise to the stereotype that it is a women's illness.

In the last decade, the literature on the relationship between gender and borderline personality disorder (BPD) has generated much controversy and little clarity. Recently, BPD has been characterized as the "bad girl" of psychiatric labels (Backer, 2000), a charge that was based on the presumption of an increase in the application of the borderline diagnosis to women and the existence of a sex bias in the clinical diagnosis of BPD (Zlotnick, Rothschild, Zimmerman 2002: 277)

Clinicians claim that BPD affects both genders equally and the only reason of aforementioned tendency is that men seek treatment less often than women and thus most of them remain under-diagnosed. Another critical explanation goes across the topic of socially imposed judgments on the gender roles. It is reasonable to assume, that the

clinicians may be initially driven by the gender stereotypes and evaluate one and the same traits differently, based on the sex of a patient. For instance, sexual promiscuity can be seen as a borderline personality disorder trait in case of woman, but may be considered as relatively normal behavior in case of a male patient. In the same manner, inappropriate anger exhibited by woman can be qualified as a BPD symptom, but deemed as more of the antisocial trait, or even a criminal behavior in case of men. This assumption suggests that mental health professionals mostly do not apply BPD to man, even if they exhibit same traits as women getting the diagnosis of BPD. The theoretical probability of the latter assumption to be true, serves as a reminder of how conditional the essence of a mental disorder label can be in terms of socially implied judgments.

2.4. Stigma of a borderline

2.4.1. Mystery of BPD

As a matter of fact, there is a huge stigma attached to the condition known as borderline personality disorder, as a result of which people labeled with it are often referred as manipulative, attention seeking and frantic. Stigma goes so far, that patients with BPD frequently get rejected from therapists, as too difficult to treat.

Ask the man on the street about anxiety, depression, or alcoholism, and he would probably be able to provide a sketchy, if not technically accurate, description of the illness. Ask him to define Borderline Personality Disorder, and he would probably give you a blank stare. Ask an experienced mental health clinician about the disorder, on the other hand, and you will get a much different response. She will sigh deeply and exclaim that of all the psychiatric patients, borderlines are the most difficult, the most dreaded, and the most to be avoided – more than schizophrenics, more than alcoholic, more than any other patient. (Kreisman, Straus 2010: 5)

The description of people with BPD offered by the clinician psychologist and a mystery writer Jonathan Kellerman in 1989 is a visible example of imposing dramatic meanings to the condition and to those qualified as borderlines. He christened patients with BPD as "a therapist's nightmare" as they "never really get better" and stated that, the best therapist can do is to "help them coast, without getting sucked into their pathology".

They are the chronically depressed, the determinedly addictive, the compulsively divorced, living from one emotional disaster to the next. Bed hoppers, stomach pumpers, freeway jumpers, and sad-eyed bench-sitters with arms stitched up like footballs and psych wounds that can never be sutured. Their egos are as fragile as spun sugar, their psyches irretrievably fragmented, like a jigsaw puzzle with crucial pieces missing. They play roles with alacrity, excel at being anyone but themselves, crave intimacy but repel it when they find it. Some of them gravitate toward stage or screen; others do their acting in more subtle ways.. Borderlines go from therapist to therapist, hoping to find a magic bullet for the crushing feelings of emptiness. They turn to chemical bullets, gobble tranquilizers and antidepressants, alcohol and cocaine. Embrace gurus and heaven-hucksters, any charismatic creep promising a quick fix of the pain. And they end up taking temporary vacations in psychiatric wards and prison cells, emerge looking good, raising everyone's hopes. Until the next letdown, real or imagined, the next excursion into self-damage. What they don't do is change. (Kellerman 1989: 113-114)

In his poetically mysterious narrative Kellerman in essence portrayed the picture of someone inherently sick without any hope to get better. Apparently, reading such lines would only strengthen feeling of despair and hopelessness in someone having the diagnosis of BPD, as well as would scare away the therapist determined to help her. The preceding paragraph can be seen as an example of the tendency of mystification and stigmatizing the diagnosis. Along such an approach condition ceases being just a diagnosis with its characteristics, but acquires additional meanings. It can be said, that mental illnesses in their nature are already implied to be understood as in some sense mysterious, but borderline personality disorder due to the complexity and turmoil it offers, appeared in the best position to be an object of dramatic mystification.

In her work *Illness as Metaphor* Susan Sontag analyses the society's tendency to approach illnesses metaphorically, giving them symbolic meanings and in so doing mystifying them, often times leading to negative outcomes for the patients. Her objects of analysis are cancer and tuberculosis. However, speaking of the tendency of approaching illnesses symbolically, it is very much possible to draw parallels between the cancer and borderline personality disorder.

As long as a particular disease is treated as an evil, invincible predator, not just a disease, most people with cancer will indeed be demoralized by learning what disease they have. The solution is hardly to stop telling cancer patients the truth, but to rectify the conception of the disease, to de-mythicize it. (Sontag 1977: 7)

Furthermore, there is an ongoing debate regarding the name of the diagnosis, suggesting that the term 'borderline' is not only imprecise, but also very stigmatizing, since it has

been used as a negative adjective, referring to too difficult and troubled patients. There have been various alternative name suggestions proposed, such as emotionally unstable personality disorder (as it is referred in ICD-10), impulsive personality disorder, emotionally impulsive personality disorder, etc. However, the proponents argue, that such alternatives pose different kind of drawbacks, as they are too specific, focused only one aspect of the disorder, such as intensity or impulsivity traits and ignoring the whole set of other major symptoms.

Linehan suggests that the stigma of BPD should be fought on the different basis, rather than replacing the label, which she thinks cannot solve the problem. She makes a very valuable point, indicating how the abnormal behavior can be understood as normal in a specific context.

Although I am no fan of the term “borderline”, I do not believe that we will reduce prejudice against these difficult-to-treat individuals by changing labels. Instead, I believe that the solution has to be the development of a theory that is based on sound scientific principles, highlighting the basis of the disordered “borderline” behaviors in “normal” responses to dysfunctional biological, psychological, and environmental events. It is by making these individuals different in principle from ourselves that we demean them. And perhaps, at times, we demean them to make them different. Once we see, however, that the principles of behavior influencing normal behavior (including our own) are the same principles influencing borderline behavior, we will more easily empathize and respond compassionately to the difficulties they present us with. (Linehan 1993: 26)

2.4.2. ‘Bunny Boilers’ - BPD and the Fictional World

As far as impact of media goes, there is not much legitimate information about BPD in popular culture, which can be one way to explain the low awareness of BPD in the general public. However there are few illustrations of BPD presented in the fiction. We can have a look at two widely popular movies associated with borderline personality disorder: *Girl Interrupted* and *Fatal Attraction*. None seem to help the situation. Rather, one simply does not clarify anything, whilst another greatly encourages stigma.

In *Girl Interrupted*, the main hero Susanna Kasen ends up in the mental hospital after her suicide attempt and gets diagnosed with borderline personality disorder. “Borderline between what and what?” – wonders Susanna hearing of the term for the first time. Her

psychiatrist does not seem to know much about the condition either. The movie takes place in the late 1960s, which in reality was the time when the diagnosis still did not have its valid meaning. Consequently, film does not contribute much in illustrating a clear picture of the condition. *Fatal Attraction*, on the other hand, portrays an unforgettably terrifying character of Alex Forrest, who after spending a night and falling in love with the married man, Dan Gallagher, refuses to let him to continue his life without her. She does numerous frantic things, cuts her wrists in a suicide attempt, spies on him, makes phone calls and even shows up at his apartment, blackmails him that she will tell his wife, pours acid on his car, kidnaps her little daughter. She goes as far as murdering and boiling a pet rabbit of the family, leaving it on the stove of their kitchen. As a final consequence, she ends up being killed after appearing in the bathroom of Dan's wife, being in a completely delusional state, attempting to murder her with a kitchen knife.

Despite the fact, that the BPD diagnosis has never been mentioned in the movie plot, some of the psychiatrists diagnosed the character with borderline personality disorder and declared her to be a very good illustration of woman with BPD. Since then, Alex Forrest has been widely associated with a 'borderline woman'. There are various papers and articles spread over the internet, indicating on the similarities between Forest and an individual with BPD. Moreover, the borderline personality disorder section in the sixth edition of *Abnormal Psychology* (1994: 267) is accompanied by the picture of Alex Forest as an example of BPD case. The caption of the portrait clarifies that she "had many characteristics of the borderline personality"(Further editions of the book have removed the stigmatizing example). Bringing forth such a disturbing example linking the dreadful image with the mental condition is the fastest way to stigmatize the diagnosis and people obtaining it. No wonder, someone whose understanding of the condition is linked to character of Alex Forrest, perceives people with BPD as scary and crazy that must be avoided by all means.

While one may say, that according to the present diagnostic criteria, character of Alex has some borderline traits, such as fear of abandonment and suicide gestures, evidently, her behavior goes far beyond that. Important aspect to mention here is that given the variety of symptomology and numerous possibilities of distinguishing between different

combinations of symptoms listed in nine criteria of DSM, the disorder may present itself very differently from person to person based on what combination of symptoms one exhibits. In this respect, it seems unreasonable to speak of the pure or classical type of a borderline patient at all.

The BPD construct is polythetic in nature and no one specific symptom is regarded as necessary. This means that there are 126 different ways that the five out of nine required symptoms can be combined. It is therefore not surprising that, from a clinical perspective, BPD is such a heterogeneous disorder. (Hooley, Cole, Gironde 2012: 410)

Moreover, as clinicians state, BPD rarely stands alone and there is high co-occurrence with other disorders, what makes the picture even more variable. With this in mind, drawing the fixed portrait of someone with BPD, applicable to all cases sounds even more preposterous.

It can be concluded from the above analysis that practice of overgeneralizing associations is utterly irrelevant when it comes to the disorder representing such a mosaic of diagnostic criteria as BPD. It can be also said, that diagnosis of borderline personality disorder is indeed the fine example of a condition the label of which is greatly empowered with the mystical and dramatic meanings attached to it.

3. Cultural Semiotics Discourse and Analytical Interviews

In the following chapter, the discussion around the mental disorder diagnosis is conceptualized in the framework of cultural semiotics. The paper puts forward the claim that receiving the diagnosis of borderline personality disorder is followed with the significant semiotic processes taking place in the consciousness of a labeled person. The primary aim of the following study is to cast the light on such supplementary processes, presenting BPD as an operative label entering a perceptive semiotic relationship with a person.

The first section of the chapter provides theoretical discourse divided into three blocks, briefly overviewing cultural semiotic theories, having a direct bearing on above-mentioned processes. The first subchapter deals with the notion of self-description and discusses the role it plays in the process of accepting and internalizing the diagnostic label. In the following block the discussion centers on the communication modeling systems, considering possible obstacles occurring in interpersonal communication for those diagnosed with mental disorder. The final subchapter overviews the notion of autocommunication and considers its appearance in the process of perceiving oneself through the prism of personality disorder label.

For the sake of providing a thorough analysis, theories discussed in the first part of the paper are particularized via case studies in the next section. Results of the online interviews that have been conducted with eleven individuals diagnosed with borderline personality disorder are carefully examined and interpreted in the light of cultural semiotics theories. The main questions asked were oriented towards three primary directions: the initial responses on the event of getting the BPD diagnosis; the tendency of establishing boundaries and obstacles encountered in the process of interaction with others; and a person's subjective reasoning in terms of experiencing oneself through the

prism of attributed diagnostic label. Accordingly, the empirical analysis is divided into three parts featuring these different aspects of the BPD label functioning. The first subchapter looks over the patient's initial responses towards the event of getting diagnosed with borderline personality disorder. The aim of this subchapter is to demonstrate the role and contextual relevance of person's self-description in regards with forming a connection with the BPD label. In the following subchapter, the issue under scrutiny is interpersonal communication and difficulties individuals diagnosed with BPD report to encounter while interacting with the people having no knowledge of their diagnosis, as well as with those having BPD. And the final part of the analysis studies the reflective processes linked to the self-addressing, where the notion of autocommunication offers important points of focus for the analysis.

3.1. Cultural Semiotics Discourse

3.1.1. Self-Description

By and large, human beings, as the self-aware creatures are capable of composing their own self-concept. Although, evaluating of self by the individual can sometimes be qualified as maladaptive from the third parties, it does not abolish its genuineness as a subjective idea about oneself. However, not getting a corresponding feedback from the outside world may affect steadiness of one's self-image, especially in instances of having a specific need of getting approval and validation from others. It can be even said that at some extent, self- image of every person is a product of outside influences. For instance, massively accepted standards of beauty may greatly affect one's idea of own physical worth, in many cases leading to lowering or heightening general self-esteem. In short, every person capable of thinking and reflecting does construct one's own self-image, whether solid or loose.

In terms of semiotics of culture (Lotman 1990: 128) self-description serves as a regulating mechanism against too much diversity within the semiosphere, threatening to

cause the loss of its systemic wholeness. Here Lotman refers to self-description as the highest form and final act of a structural organization. However, he outlines that although the system going through the stage of self-description reaches the greater structural organization, it loses inner reserves of indeterminacy “which provide it with flexibility, heightened capacity for information and the potential for dynamic development”.

Applying aforementioned notion to the individuals diagnosed with a mental disorder, it must be taken into account, that a person gets introduced with already existing typological description of the diagnosis and evaluates whether it corresponds or not to their concept of self. In the former instance, the individual places oneself in the general category and in so doing, at some extent limits self to the determined structure. The question of which is the chicken and which is the egg may arise here, concerned with the issue of whether a self-concept plainly matches with a diagnostic description, or the latter shapes the former.

Speaking of categorical descriptions, with no intention to draw the parallels between astrology and psychiatry, the example of twelve zodiac signs can be brought. To leave aside the context and the degree of validness, astrology differentiates twelve personality types in accordance of zodiac signs, attributing exclusive traits to each signs. Many claim to recognize themselves among the features accounted to the particular zodiac sign. Yet, not everyone familiar with the astrological classification of signs identifies oneself with her zodiac sign, qualifying the characterization of possessed sign as irrelevant to their personality. This mere example may suggest that self-analysis must be the starting point and underlying factor to form the synthesis with the description offered. However, Lotman clarifies that the gap between forming a self-concept and processes bringing it into being is not so clear-cut.

The system, passing through the stage of self-description, undergoes changes: assigning to itself clear boundaries and a considerably higher degree of unification. However, separation of the process of self-description from the state preceding it is possible only in a theoretical sense. In reality both levels continuously influence each other. (Lotman 2009: 172)

On these grounds, going back to the chicken-egg problem, it can be said that self-descriptive process is a dynamic movement carrying a reciprocal relationship with the

concepts it merges with. Accordingly, self-concept of a psychiatrically diagnosed person is much likely to acquire position of influencing the concept in a sense of internalizing it, as well as getting influenced with the integration formed. Furthermore, speaking of dynamics of culture, Lotman develops the claim that there is a mutual tension between culture's internal structure and external influences.

Thus, an "external" culture in order to enter into our world must cease to be "external" to it. It must find for itself a name and a place in the language of the culture into which it seeks to insert itself. But in order to change from "alien" (chuzhoi) to "own" (svoi) this external culture must, as we can see, submit to a new name in the language of the "internal" culture. The process of renaming does not take place without leaving a trace of that content which has received the new name. (Lotman 2009: 133)

Conceptualizing the theory of culture dynamics on the individual level, it seems possible to draw parallels between the abovementioned collision and internalization of a mental disorder label. Corresponding to person's self-concept, the label covering a diagnostic criteria ceases being external and becomes owned, giving rise to the division of world into 'us' and 'them' in its turn.

3.1.2. Communication Modeling Systems

Lotman sets off two possible scenarios concerning communication between the addresser and the addressee. In one instance "the mechanism of communication is inherently given, but the content of communication is theoretically absent; in the other situation, the content of communication is inherently given, but the mechanism of communication is theoretically absent." (Lotman 1977: 96) Lotman clarifies bringing the example of two humans not capable of using regular sign language in the communication, but signaling each other via their involuntary psychological or physiological symptoms. Supposing both individuals share the common code set allowing each to access and process signals coming from another, it can be said that a fundamental mechanism for semiotic communication is present, but a content for exchange is absent, as both parties transfer identical meanings. Following, Lotman suggests that the meaningful and functional semiotic communication is achievable by means of finding the balance between those

two systems. "At the basis of every act of exchange lies the contradictory formula, "equivalent but different": the first part of the formula makes an exchange technically possible and the second part makes it meaning full in content." (1977: 96)

On these grounds, we can put forward the issue of communication between individuals diagnosed with the same mental disorder, exhibiting the same set of symptoms and their interpersonal communication with mentally healthy people. As those diagnosed with BPD or any other mental disorder share the initial set of codes concerning the features of their diagnosis, they are capable to decipher the messages sent in the direction of each other. However, the content exchanged in such cases is mostly similar and less likely provides valuably new information for the participants of a dialogue. That is, is not "full in content". Rather, standing on the mutual understanding of familiar feelings, fulfills an empathic function, providing support and understanding. On the other hand, interaction with people, not connected to the diagnosis and not having the basic knowledge of it, may create difficulties for both sides, as one may feel misunderstood and not heard, while another may find oneself being confused and lost. Although in terms of exchanging the content such a conversation would be fruitful, the lack of commonly shared codes would affect the level of intelligibility and mutual translatability of the information.

The communication based on a specific type of information, such as the psychiatric knowledge of a personality disorder, is likely to be understood by only a small number of people. Thus, it may create difficulties in a whole series of cases, resulting in incomplete semiotic communication. The message transmitted, which is difficult to decipher gets interpreted by the recipient of information on his own terms, often times qualified as misinterpretation by the addresser.

The more complex the structure of a message, the more individual is its interpretation by each recipient of the information. The act of exchanging information ceases to be a passive transfer of a message that is adequate onto itself from one bloc of memory to another and becomes a translation, in the course of which the message is transformed and the striving for adequacy enters into dramatic conflict with the impossibility of its complete realization. The act of communication begins to include the aspect of tension within itself. (Lotman 1977: 97-98)

Furthermore, along the lines of individual texts oriented towards addresser and addressee, authors of Tartu-Moscow Semiotic School distinguish between the cultures oriented

towards the hearer and the speaker.

An example of a culture oriented toward the hearer would be one in which the axiological hierarchy of texts is arranged in such a way that the concepts “most valuable” and “most intelligible” coincide. [...] A culture oriented toward the speaker possesses as its highest value the sphere of closed, inaccessible, or completely unintelligible texts. It is a culture of the esoteric type. [...] The orientation of the culture toward the “speaker” (addressor) or the “hearer” (addressee) will be revealed in the fact that in the first case the audience models itself according to the pattern of the creator of the texts (the reader seeks to approach the poet’s ideal); in the second case, the sender constructs himself according to the pattern of the audience (the poet seeks to approach the reader’s ideal). (Lotman, Ivanov, Pjatigorskij, Toporov, Uspenskij 2013: 60)

In this respect, it can be suggested that the information on the mental disorder transmitted by the individuals diagnosed with one, by its semiotic nature is oriented towards the speaker. In regards of unintelligibility of a text, the picture may somewhat change with an attempt of addresser to simplify the message, by means of avoiding the use of specific diagnostic language for instance. However, it perhaps does not change the orientation of communication altogether, as the addresser stays in the position to provide the information about oneself, which requires specific knowledge to be comprehended by the recipient.

3.1.3. Autocommunication

Usually, while we speak of the communication we tend to picture the plain scheme of participants exchanging the information between one another. In short, any activity whereas the information is mutually transmitted, processed and reflected can be qualified as what Lotman calls a communication with ‘I-S/he’ direction. As suggested, this type of communication renders the message that has been unknown to the recipient before the conversation took the place. While pointing out a prevalence of the aforementioned orientation, Lotman gives introduction to the ‘I-I’ direction of the communication. ‘I-I’ direction takes place when a person addresses oneself, conveying already known information. Autocommunication does not aim for remembering something that would make it more similar to ‘I-She’ direction.

When we speak of communicating a message by the 'I-I' system we are not thinking primarily of those cases where the text fulfills a mnemonic function. When that happens he perceiving, second, 'I' is functionally equivalent to a third party. The difference comes down to the fact that while in the 'I-s/he' system information is transferred in space, in the 'I-I' system it is transferred in time" (Lotman 1990: 21)

Following, the essential purpose of autocommunication derived from the 'I-I' direction, is reflecting on already existing information, rather than providing the new ones. In this respect, autocommunication is concerned with the reception of code and providing the reflective response on this code. In other words, autocommunication serves as a contemplating mechanism for one's state of mind, resulting in creation of new meanings and refashioning of self.

In the 'I-I' system the bearer of the information remains the same but the message is reformulated and acquires new meaning during the communication process. [...] The 'I-s/he' system allows one merely to transmit a constant quantity of information, whereas the 'I-I' system qualitatively transforms the information, and this leads to a restructuring of the actual 'I' itself. In the first system the addresser transmits a message to another person, the addressee, but remains the same in the course of the act. In the second system, while communicating with him/herself, the addresser inwardly reconstructs his/her essence, since the essence of a personality may be thought of as an individual set of socially significant codes, and this set changes during the act of communication. (Lotman 1990: 22)

The definition cited above makes obvious the important place autocommunication holds in analysis of person's relationship with her label, which in case of the following study is borderline personality disorder. Getting the latter diagnosis and familiarizing oneself with its essence, a person gets engaged in the communication whereas she is both the addresser and addressee, reflecting on the acquired information on BPD and drawing new meanings about oneself.

In the process of this autocommunication the actual person is reformed and this process is connected with a very wide range of cultural functions, ranging from the sense of individual existence which in some types of culture is essential, to self-discovery and auto- psychotherapy. (Lotman 1990: 29)

Following, seeing their self in a new light, a person may take the diagnosis as a superior component of the personality, leading to the tendency of perceiving oneself through the lenses of acquired label. Such a fusion with the mental disorder label may create difficulties with the intrapersonal functioning and rational judgement, blurring the lines between the personality traits and diagnostic features. On the other hand, practicing

reflective thinking may fulfill the function of increasing one's awareness, resulting in sharpening the boundaries between the self and label instead.

3.2. The Analysis of Interviews

3.2.1. A Relief or a Death Sentence? – Initial Responses

While it can be assumed that getting diagnosed with the illness occurs as a negative event in one's life, the event may contain beneficial aspects to the person. As the results obtained from the interviews demonstrate, the response to getting borderline personality disorder label contains the significant relieving aspects. As a matter of fact, nine out of the eleven interviewed persons state that finding out they had BPD was to some degree a relieving experience. Some of the extracts from the interviews, demonstrating a foregoing tendency are cited below.

-It was a relief for me because we finally put a name to something we had been puzzled about for several years. (Daniel C.H.)

-I would say I felt relief. I felt this way because it let me know that yeah, I am different but at least I know why now. (Taylor O.)

-There was a mixture. First there was relief because I now knew what was happening had a name and could be identified. (Charles R.P.)

- I felt good and comfortable with it. I felt that finally there was a reason why I was why I am. I wasn't just a crazy bitch. (Ashley H.)

-It was a relief. It made sense of the way I had been feeling. It wasn't my fault, all the things I had felt, thought and done. (Helen L.)

-It was both fear and relief. I was relieved because I finally had a name for the monster following me around. (Jade T.)

-I felt relieved to know I wasn't "crazy". I was scared and happy.... it's hard to pin point my feelings. But I was for sure relieved to be able to put a label on it. (Samantha T.)

-I was scared but at the same time I was relieved. Relieved in the way that I finally knew what was wrong with me. (Emilisse R.M.)

As may be seen above, finding the name for the condition, that is putting the label on

one's cognitive and behavioral pattern, may serve as the clarifying mechanism, determining obscure and undefined elements of personality. Looking back to the example of astrological classification of signs, pointed out in 3.1.1, it becomes apparent that in regards to mental illnesses, categorical descriptions of personality types are and have to be far more bound and determined. Certainly, astrological classifications, which mainly have acquired entertaining function, are universal, as every single person can be labeled with one.

Considering their specific context, diagnostic manuals of mental disorders, on the other hand, are not normally inquired without the presence of undesirable symptoms that can also serve as the intensifier of the need to match a self-concept with a classification, which may seem as a promising mechanism to get the answers on the abundant questions. Accordingly, regardless the negative context getting diagnosed with mental illness bears, it may have a soothing effect on the person, struggling to figure out oneself.

The notion of self-description discussed in the previous section becomes of importance here, as it can be said that the diagnosis fulfills the function of regulating instrument for person's self-concept. The data gathered does not imply, that a person has no concept of self until gaining the BPD label and it creates one in a strict sense. Rather, the point indicates that the unsettled elements of self-description become organized and in a sense justified after putting a diagnostic label on them. Remembering the process of receiving borderline personality disorder diagnosis, Ashley H. mentions that she has never heard of BPD before, but immediately recognized it as her diagnosis as she got familiar with its essence.

I first learned of my diagnosis when I woke up on my second day, or third, in the hospital. The nurse had brought in paperwork of what the doctor diagnosed me with. I read the papers and immediately felt panicky. Later that morning I saw the counselor and we talked and he broke BPD down for me and I had a "that's totally me" moment.

In fact, most of the interviewees claim that learning about borderline personality disorder, they instantly acknowledged and accepted it as the right diagnosis. Some report having the information about BPD long before getting diagnosed. Thus, for them, getting the

official diagnosis was only a confirmation of what they have accepted in advance. Brittany R. D. notes that she suspected having BPD six years before getting the actual diagnosis.

I believed I had it when I realized I didn't feel any emotions to an acceptable degree. I was either overly sensitive to it, or felt nothing at all. I lived with it and dealt with it on my own until a year ago when the panic attacks started. I was struggling just to get out of bed in the morning. I cried nightly because I felt like everyone, including family, hated me. I thought people were only nice to me because they wanted to find reason to laugh at me behind my back. I had a constant battle with my mind.

Along similar lines, Rebecka C., previously misdiagnosed with clinical depression and bipolar disorder, states that she was aware of having BPD, but it took more time for mental health specialists to recognize it too. "I never felt like depression or bipolar disorder fit completely, so it was almost a sense of "this is where I belong." Recalling her high school age, Taylor O. also affirms recognizing BPD as her disorder long before being labeled with it.

It all started when I was 13 and just kept getting worse until I just recently got help.. I knew I was different after 3 suicide attempts and self harm. I remember in a high school psychology class we were learning about BPD and I thought wow, that sounds exactly like me, but I was too ashamed to get help.

The cases noted above illustrate the initial dynamics of self-descriptive system, orienting itself towards reasoning. Finding the right structure corresponding to its nature, concept of self gets fused with it, simultaneously absorbing it and getting absorbed by it. To clarify, it can be said that the label serves as a tool giving form to undefined states of mind in in so doing justifies, legitimates and in a sense even normalizes them. The responses cited below can serve as an excellent example of such a tendency.

-After I found out, it was like obtaining missing puzzle pieces to a puzzle I didn't know I was working on. Every thing just made sense. (Samantha T.)

-I finally understood why I always felt like an outsider, a stranger to happiness. And for the first time ever.. It felt like I was born. That I knew who I finally was and that I had to deal with her now or never. (Emilisse R.M.)

3.2.2. 'Us' and 'Them' – Difficulties with Communication

Speaking of proper names, Lotman points out (2009: 31) that the use of them is inherently linked with the isolation of individual personality. Although, linguistically speaking mental disorder labels are common nouns, not the proper names, the specific signification carried make them perceivable as such.

No less significant are the various taboos placed on proper names; on the other hand, the placing of taboos on common nouns (for example, the names of animals, sicknesses, etc.) definitely indicates in a whole series of cases that the corresponding designations are perceived (and, accordingly, function in the mythological model of the world) precisely as proper names. (Lotman, Uspensky 1978: 214)

Following, a mental disorder label may function as a proper name and encourage the practice of embedding the boundaries between individuals with psychological vulnerabilities and mentally healthy people. The initial theoretical foundation for the construction of a dividing wall lies in the sense of difference between 'us' and 'them'. Individuals, aware of their diagnosis, hence having more structured concept of self, are able to point finger on the major differences between them and those regarded as mentally healthy people. Experiencing emotions more intensely is the most commonly identified distinctive feature named by the research participants.

My world is just more intense. Everything is felt ten fold. I've had some extremely traumatic things happen in my life, like most with BPD, and I've had people say to me that anyone who experienced that would not be the same when all is said and done. What they don't realize is that I was broken long before those things happened, so where a normal person would have been shaken, I was absolutely devastated. I have flashbacks to those times out of nowhere. I remember what it smelled like, what I saw, what I heard... It's just way more intense. (Rebecka C.)

As may be seen above, Rebecka C, understanding self in relation to the other, clearly differentiates between her and 'a normal person' and stresses the major difference coming down to the level of emotional vulnerability. She also mentions facing a lot of difficulties on a daily basis "that most people could not imagine dealing with for even an hour". Similarly, other respondents indicate on their extreme emotional reactions and not being able to balance their feelings.

-My emotions are times 10. I can't just be sad, I have to be breaking down crying. I can't

be upset I'm so pissed off I want to kill someone. My emotions are my worst trait.
(Ashley H.)

-I feel emotions either so powerfully that that they send me into a panic or they are not there at all and I can come off as cold and uncaring when I'm actually very caring.
(Brittany R.D.)

Charles R.P. for the most part identifies himself with the rest of the society, however recognizes the differences too. "I would say, philosophically I can't say I am not them. However, I know in a logical sense that healthier people live a much less chaotic life". Representing a gender minority of people diagnosed with borderline personality disorder, he further reports experiencing the additional difficulty to identify self with "the mostly female world of BPD". The latter line of thought depicts the presence of boundaries, operating even within the world of one diagnostic entity. Despite of sharing the same label, a person assuming a role of minority may feel detached from the group. Evidently, the need of being properly understood in order to establish a working connection with the outer world is a fundamental human need. Jessica R.M. qualifies the world of people with BPD as more difficult, "because we are less understood". To be understood, at first one needs to get engaged in a communicative activity. Yet, establishment of such communicative activities seems to be a challenging mission for those labeled with borderline personality disorder.

As it was discussed in the previous section, providing the complete semiotic communication is greatly dependent on the right balance between two aspects – technicality and meaningfulness. The difficulties encountered in the communication pointed out by the interviewees display the lack of the balance mentioned above. Nearly every person interviewed finds it challenging to communicate with people having no proper knowledge of borderline personality disorder. The primary obstacles outlined are elements of stigmatization coming through the addressee and their own difficulty to explain different manifestations of the disorder understandably for those they are communicating with.

-I find it very challenging to explain to people who do not understand the disorder.
(Jessica R.M.)

-I feel it is very hard to talk about this illness with someone who doesn't have it. (Taylor

O.)

- I don't really have any experience communicating with other BPD people but I imagine I would be more mindful of what I say and how someone might react. It is not uncommon for me to read something 5 or 6 times when messaging anyone at all, in case I may upset them or seem a bit blunt about things. (Daniel C.H.)

-I find it particularly difficult to share because I often end up feeling invalidated when talking about it. I've heard from many people, "oh, I get like that too," "it's probably just PMS," "well, just be more positive and you'll feel better," and just this past Christmas my sister and best friend said, "I just don't have time to deal with you being depressing." And when you get comments like that from people who love you, it's extremely intimidating to put it out to strangers. Few people have ever heard of BPD, let alone know what it actually is. And the few that think they do know what it is only think so because they saw it on TV. So, odds are that their perception is not correct.(Rebecka C.)

-The biggest difficulty is the lack of understanding from people that don't have any knowledge of BPD. My boyfriend's signature line is "I don't understand" and I always say exactly you don't, and you never will. People who care about us try to understand but they will never fully be able to. (Ashley H.)

The last assertion from the above list demonstrates how immense the wall built between 'us' and 'them' can be. In such instances, the communication with anyone but member of 'us' is already predestined for a failure, as the addresser deems the addressee incapable to fully comprehend the content transmitted to his direction. The content for the meaningful exchange is present, but the mechanism enabling the convenient decipherment seems to be missing. On the logical grounds, one of the hindering factors for the transmission of intelligible text can be the use of metalanguage, as most of the mental illnesses BPD also presents its symptom specific terminology, widely adapted by mental health specialists as well as their patients. However, according to the results of individual interviews, the employment of BPD-specific language is not what gets in the way, since such a tendency is mostly absent among those interviewed. Moreover, respondents report that they try to simplify the information they share about their disorder, to reduce chances of further confusion.

-I try not to use terms that will confuse people further. I try to describe it metaphorically so people can relate to what I feel. (Brittany R.D.)

-I never use those types of words. I feel like people don't understand it. Sometimes even I don't understand it. (Taylor O.)

-Even when I'm talking to a doctor or therapist, I don't use terms like that. (Ashley H.)

The person affirming to use the specific diagnostic vocabulary explains it as her attempt to make her friends more familiar with the disorder.

-I want them to know and learn what BPD is and what it consists of. Just this morning, I was sitting in the University yard in a 15min class break and after I had muffin, I started to cry about the dang muffin and my friend had to console me cause I had felt bad that I had eaten the muffin but I still wanted more. At that moment she learned what Binge Eating is and I explained how it can also be associated with my BPD, myself image and stress levels. (Emilisse R.M.)

As the findings suggest, individuals with borderline personality disorder are likely to feel either misunderstood or not understood at all while expressing themselves to mentally healthy people. As the addresser and the addressee do not share the common code, do not speak the same language so to say, the message transmitted requires the translation in the mind of recipient to be comprehended. This very act of encoding the information tends to be unsuccessful, at least from the point of view of addresser, resulting in the failure of the communication on the whole.

With this in mind, one may presume that a communication whereas both parties are diagnosed with the same disorder must be successful and semiotically complete, as both the transmitter and the receiver of message would share the common code, enabling each to properly comprehend the information. However, as discussed in the previous section, in such

instances the problem would not be eliminated, but replaced with different type of difficulty. That is, although technically the information would be successfully transmitted through both directions, the content for exchange would be missing. Moreover, Lotman states (1974: 303) that the use of one and the same code by the collective, results in composing of semiotically uniform individuals, losing their individuality.

While some of the participants state to feel much more comfortable while communicating with other people having borderline personality disorder, the reason of which is that “they know the struggle of it”, others specify the difficulties they encounter having a conversation with someone sharing the diagnostic label with them.

- Having two BPDs together I feel like there will be a lot of hurt feelings but they will

understand where you are coming from. On the other hand speaking with someone who has no idea what it is like just thinks you are too sensitive or too emotional. So I feel like it can be rough either way.

-Actually I find it difficult to talk with others with my same experiences. It seems to turn into a "my horse is bigger than your horse" discussion. (Brittany R.D.)

-Talking to other people with BPD is helpful because they get it. They get the moods that come on for no reason. But at the same time, a lot of the time it seems like it's almost a 'who has it worse' competition. (Ashley H.)

The sentiments expressed in these examples can be boiled down to the problem of sharing the single code and 'speaking the same language', which at first glance may seem to be nothing else but a guarantee for the establishment of a flawless communicative channel. Regardless of the fact that both participants are able to make perfect sense of what another person has to say, a conversation is disposed to create the circle of circulating the same information over and over again. Given that participators of such interaction are engaged in the equivalent exchange of identical messages that provides no novel information for them, it may take the form of competition, with an attempt to make own information qualitatively different from another's.

3.3.3. 'Because I have BPD' - Reflecting on the diagnosis

A person who internalizes her diagnostic label is likely to begin perceiving self through the lenses of the diagnosis. Naturally, the convergence of a person and a label may stipulate the tendency of seeing oneself in a total new light. The whole majority of individuals interviewed declare that they fully accept BPD diagnosis as an inherent part of them. "I would like to say that I am not my illness, but to a point I am. And if someone can't handle my illness, they can't handle me"(Rebecka C.). Yet, some have developed slightly different understanding of the concept, interpreting the diagnosis as their irrational side, which at times takes over their rational side and this is when it becomes the big part of them. "I guess you could say that I do perceive it as separate until it takes

me over” (Brittany R.D.).

Following, a label’s manifestation of itself as a core element of one’s personality, may lead to the experiencing a confusion regarding the shift between a personality and the diagnosis manifesting itself in the certain situations. Depending to the degree of fusion experienced by the individual, a line between normal behavior and disordered conduct may get quite blurred

-I constantly have to ask people if my reactions are justified or if I am letting BPD take over. It is always blurry like what I should feel and what I am feeling. (Taylor O.)

-Sometimes I wonder how I would react if I didn't have BPD. (Jessica R.M.)

-I have always been a very sensitive person, so when the intense emotions hit, it's hard to tell if it's me or my illness. (Rebecka C.)

Furthermore, the tendency of justifying thoughts and behavior in terms of the diagnosis is present. Talking about her emotional responses towards both positive and negative instances, Helen L. qualifies herself as more responsive to the environment, than most of the people. She brings an example of taking a walk at night, making her feel happy for no reason and connects it to her diagnosis.

I stare at the trees for instance, it makes me feel happy and I think it is because of my disorder, because I do not see or hear other people doing the same. When the situation is bad though, I feel so terrible, sometimes way worse than I should and what should be a normal response. I'm irrational.

Following, comparing herself with other people, Emilisse R.M. expresses the similar sentiment.

I can see this calmness in others people lives that I don’t think I’ll ever have. Because as someone with BPD, I find myself fighting with my own thoughts, emotions and I tend to repress certain types of ways to express them. I don’t think normal people go through this.

As illustrated, speaking of their emotional experiences both individuals refer to their diagnosis, as the explanation of states of mind qualified as abnormal. The label here provides some degree of authority within which experiences deviating from the standard norm acquire their legit value. That is, even something 'abnormal' may get normalized in its context, being covered by the diagnostic label.

I justify my emotions when I get very angry at times. I was happy to read about that symptom from DSM, it was not in ICD. I had felt ashamed for being so angry before. Now I know why I get that way and it makes it easier to control. (Helen L.)

There is an evident relationship between the tendencies discussed and the notion of autocommunication overviewed in the subchapter 3.1.3. Clearly, the contemplated thoughts presented above are derived from 'I-I' type of communication. A person draws conclusions in regards of her relationship with the diagnosis, which given the vagueness of the subject, at times leads to the natural confusion, creating further questions. Following, a person begins addressing oneself, transmitting already known information from 'I' to 'I' and reflecting on it as a result of which information that stays the same acquires a new supplementary meaning. The primary tool of reflection is the fact of having BPD, as this is what explains and justifies atypical organization of personality. In this respect, it can be said that information of having BPD serves as a code following the messages addressed to oneself. Lotman very clearly explains the difference between the functions of the message and the code in the process of autocommunication.

Fundamentally speaking, a text is used as code and not message when it does not add to the information we already have, but when it transforms the self-understanding of the person who has engendered the text and when it transfers already existing messages into a new system of meanings. If reader N receives the message that a certain woman called Anna Karenina has as a result of an unhappy love affair thrown herself under a train, and if that reader instead of adding this information to what she already has in her memory, comes to the conclusion: 'Anna Karenina is me' and starts changing her understanding of herself, her relationships with people and perhaps even her behavior, then obviously she is using the novel not as a message like any other, but as a kind of code in her own process of self-communication." (Lotman 1990: 30)

Apparently, there is a good match between the example of 'Anna Karenina is me' brought into light by Lotman and 'BPD is me' mental outlook within which self-analysis take place. However, in case of diagnostic manuals, as discussed earlier, it should not be understood strictly as the copying a behavior, but as internalizing it, once recognized as 'own model of behavior'. Speaking of 'I-I' communication, Lotman also brought the example (1990: 21) a person writing the diary jottings, with the main purpose to elucidate the writer's inner state. Further corresponding examples of such self-analytical ruminating operations are brought by the interviewed individuals, talking about the train of thought they tend to contemplate, while searching for the possible triggers of their

behavior.

-Every strong feeling or thought I have is analyzed and processed as a witness not as a fact. In this way, I can balance my feelings/reactions better and have a better-balanced life. (Charles R.P.)

-It depends on the situation but I mostly tend to look through the day, search for the possible trigger that could have started my little domino effect. (Emilisse R.M.)

Apart from the confusion and justification individuals labeled with BPD seem to engage in autocommunication for the therapeutic purposes as well. Some of the interviewees revealed an interesting tendency of speaking about themselves in a much more positive manner while considering their diagnosis, that is using the code 'I have BPD' than without it. When asked how would they describe themselves if they had never heard of borderline personality disorder, some of the respondents used very negative and self-stigmatazing adjectives. However, when asked to take into account their diagnosis, they revealed much more self- tolerance. For instance, "inhuman" and "out of control" was changed with "understanding". The way Ashley H. refers to herself overlooking her diagnosis and then taking it into account is a very fine example of the label's capacity to generate new meanings about oneself.

-I was just an angry, emotional bitch. That's how I always described myself, and how people described me. No one ever enjoyed being around me. I was just a shitty person.

- Well, I think I'm still an emotional basketcase sometimes but I know now more or less that I have to take a breath before I say or do anything. I've gotten my anger issues under control a lot more too. So, I'm a calmer person I think now that I'm aware of my diagnosis.

Furthermore, the response of Daniel C.H. "A good guy at heart but struggling with something that I have little to no control over"- is another visible example of the autocommunicative reflection. The individual recognizes his problems, addresses them to self and reflecting upon them through the code 'I have BPD' concludes to be a good person, who has a little control over the way things are with him. That is, the information about having the problems does not change, but acquires a new meaning.

One more outcome of self-addressing in those with BPD seems be the ability to analyze the pleasant side of their diagnosis. Some of the individuals reveal a tendency to connect

not only undesirable, but also their positive features to the borderline personality disorder.

Despite all of the negatives, there are some positives that I get from it, like immense creativity, empathy sometimes to a fault, passion for everything I do, and a huge heart with so much love to give to others. I really relate to the quote "It is both a blessing and a curse to feel so intensely. (Rebecka C.)

As it can be seen from the analysis, the diagnostic label of BPD certainly serves as a meaning-generator unit, entering into the specific relationship with a person obtaining it. Besides the internal 'mysterious' nature of it as a mental illness diagnosis, the additional meanings attached to it and the level of its complexity makes this relationship process semiotically more sophisticated.

Conclusion

The thesis presented a comprehensive account of the relationship, taking place between a label of a mental illness diagnosis and a person obtaining it. The descriptive analysis of the general topic of mental health, its history and the thorough overview of the study object itself made the paper interdisciplinary approachable.

The theoretical discourse regarding the dilemma concerning the validity of mental illnesses showed the possibility of expanding the horizon and comprehending the subject matter more extensively. It demonstrated that the very notions of the abnormality and illness can be boiled down to the problem of subjectivity. Thus, making the radical statements on the essence of such concepts proves itself as an unreasonable practice.

Given its position to study the meaning-making processes, in large part semiotics can serve as a way to broaden the perspectives of comprehending the full picture of the various problematic topics.

In the present work, the valuable theories of cultural semiotics proved themselves helpful in analyzing such an intriguing and by its nature complicated interconnection as a relationship of a person and a mental illness diagnosis. The notions of self-description, communication modeling systems and autocommunication have been of a great use in the process of exploring the terrains of diagnostic world of BPD and the operative nature of its label.

Empirical part of the analysis has acquired the major significance for the better understanding of the aspects discussed theoretically. Insights and visions offered by the individuals directly connected to the study object is a valuable addition to the theoretical discourse presented in the thesis. Cultural semiotic approach to the manifestation of the BPD diagnosis expands the horizon and broadens perspective of comprehending the nature of mental disorder label.

Based on the general results, it is possible to conclude that the research into mental health related problems, such as stigma, public unawareness, problem of subjectivity and individual perceptions and the supplementary processes of getting the diagnosis can be relevant to the field of semiotics. Moreover, it can be said that semiotic accounts on the aforementioned topic can greatly contribute to the better understanding of the issues and providing the alternative ways of approaching the problems of mental health.

Further research is required in regards the role of gender in the clinical world of BPD and other mental disorder. Several questions on the topic remain to be addressed, requiring more research. The study of the issue would be of interest for the people from different disciplines, given the theoretical premises of the subject. Certainly, the topic positions itself as a promising topic for another semiotic analysis, as concentrating on this aspect may unfold an interesting cryptic linked with the social implications in regards of gender roles, possibly affecting such cases as getting the mental illness diagnosis.

To the author's best knowledge there is no semiotic paper written on the relationship between a mental illness label and its bearer specifically. On these terms, the work introduced a novel subject matter for the research, with the hope to draw a significant attention to the topic of mental health and its relevance for the science of semiotics.

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Appendix 1

The Interview Questions

1. When did you get diagnosed with borderline personality disorder and what preceded it?
2. What made you think (if so) that you might have some mental illness?
3. Was getting BPD diagnosis the first time you heard of this disorder or you already had some information about it?
4. What was your first reaction/emotion when you heard of your diagnosis? Was it scary? Unpleasant? Or did you feel some kind of relief? Please specify why?
5. Are you comfortable with telling people that you have borderline personality disorder? Why? Why not?
6. Do you experience any elements of stigma when you tell people (if so) about your diagnosis?
7. Do you find it easier to communicate with people with BPD or at least familiar with the disorder? And what are the main difficulties you encounter (if so) while communicating with people having no knowledge of BPD?
8. Do you usually use BPD specific language, while talking about your emotional experiences (Splitting, dissociating, etc)? Do you find it challenging to describe these feelings to someone not familiar with the disorder and its characteristics?
9. Out of all the BPD symptoms and traits what are the most difficult for you to deal with?
10. How often do you explain/justify your behavior or emotions/perceptions in terms of BPD (To yourself)? Can you give some examples?
11. How would you say your world as someone with BPD differs from other's world?
12. Do you sometimes experience confusion whether your reactions/emotions are 'normal' and 'justified' or it is BPD taking over? Can you give some examples?
13. How much of you is BPD? Meaning, do you perceive your diagnosis as something separated from your identity, or do you experience sort of fusion and take it as a part of you?
14. How would you describe your personality if you had never heard of borderline personality disorder?

15.How would you describe yourself considering your diagnosis?

Summary in Estonian

Magistritöö „Semiootiline vaatepunkt Piirialast Tüüpi Isiksusehäirele“ uurib selle diagnoosiga määratletud isikute nii enessesse kui ka nimetusse suhestumist. Töö on jaotatud kolme suuremasse ossa ning hõlmab nii teoreetilist kui ka empiirilist analüüsi.

Esimene osa keskendub vaimuhaiguse määramisega seotud probleemidele. Keskseks vastanduseks on vaimuhaiguse mõistmine ühest küljest temas eneses, objektiivselt ja essentsiaalselt ning teisest küljest isiku subjektiivse kogemuse toel. Siinkohal osutub suhestumine diagnoosiga esmatähtsaks.

Püüeldes interdistsiplinaarsuse poole, esitab töö nii ajaloolise kui ka deskriptiivse ülevaate Piiripealset Tüüpi Isiksusehäirest. Järelduste tegemisel on arvesse võetud mõlemat, ajaloolist tausta ja kaasaegset psühhiaatrilist teadmist.

Töö viimane osa lisab metoodilisse lähenemisse kultuurisemiootika ning uurib piiripealse häirega isikutega sooritatud intervjuusid. Peatükk analüüsib piiripealse häire nimetuse (diagnoosi) ja isiku semiootilist suhestumist.

Arvestades analüüsi tulemusi, soovib autor rõhutada semiootilise lähenemise tähtsust vaimse tervise probleemidele lähenemisel.

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